Florida's Maternal, Infant and Early Childhood Home Visiting Program

HEALTH

Florida's Maternal, Infant, and Early Childhood Home Visiting Updated State Plan

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ACKNOWLEDGEMENTS

The completion of Florida's Updated State Plan is the result of a partnership between the Department of Health and the Department of Children and Families, to establish a program with the overall goal of improving the well-being of families across Florida. This collaboration created the Maternal, Infant, and Early Childhood Home Visiting Co-Leader Workgroup whose members include: Annette Phelps, Dr. Bill Sappenfield, Carol Scoggins, Marianna Tutwiler, Susan Potts, and Javier Vazquez from the Department of Health; and Johanna Hatcher, Linda Radigan, and Dee Richter from the Department of Children and Families. The Workgroup has met weekly since December 2010 to plan and carry out this initiative.

The Department of Health and the Department of Children and Families would like to especially thank all the entities for submitting responses to our Request for Applications. These entities include: the Broward Healthy Start Coalition; the Gadsden County Healthy Start Coalition; the Healthy Start Coalition of Jefferson, Madison, and Taylor; the Healthy Start of North Central Florida Coalition; the Northeast Florida Healthy Start Coalition; Heartland for Children; the Collier County Health Department; Northwest Florida Comprehensive Services for Children; the Healthy Start Coalition of Pinellas; the Children's Home Society of Florida; the Osceola County Health Department; Orlando Health; and the Healthy Start Coalition of Hillsborough County.

BACKGROUND

Section 2951 of The Patient Protection and Affordable Care Act of 2010 (ACA), an amendment to Title V of the Social Security Act, was signed into law on March 23, 2010. This historic legislation created Section 511: Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Programs, whose purpose is threefold:

- Strengthen and improve the programs and activities carried out under Title V;
- Improve coordination of services for at-risk communities; and
- Identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

On June 10, 2010, the United States Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), and the Administration for Children and Families (ACF) jointly issued a Funding Opportunity Announcement (FOA). The FOA outlined a three-step application process offering grants to eligible states to support home visiting (HV) services to pregnant women, infants, and young children in identified high-risk communities.

Florida's former Governor Charlie Crist officially designated DOH as the lead agency to apply for the MIECHV Program funding on July 6, 2010.

The Florida Department of Health (DOH) and the Florida Department of Children and Families (DCF) (the Departments) signed a Memorandum of Agreement (MOA) that outlined their individual and collective responsibilities. The MOA establishes collaboration between the Departments in applying for the HV grant and builds on their longstanding affiliation of working together to protect children and families. The Departments are poised to embrace the opportunity to align their common priorities with those of the new HV legislation.

To facilitate decision making, a group of team leaders was selected from DOH and DCF based on professional experience and their roles with respect to the HV program. The workgroup consists of an epidemiologist (DOH), data researchers (DOH and DCF), departmental co-leaders (DOH and DCF), administrator representing Community-Based Child Abuse Prevention (CBCAP), substance abuse, and mental health programs (DCF), Maternal and Child Health Division Director (DOH) as well as the program administrator and medical analyst (DOH) hired to implement the HV program. This group, given the name "MIECHV Leadership Workgroup" (workgroup), has met weekly since December 2010 to discuss the possibilities and challenges related to planning the implementation activities of this program and to make decisions as appropriate.

The DOH in collaboration with the DCF submitted the grant application required in Step 1 on July 8, 2010, and was awarded the initial $500,000 allocation of grant funds allotted to states reaching this level of eligibility.

In April 2011, an evaluation team was selected to guide the evaluation efforts. A Home Visiting Advisory Committee was established with membership from a broad spectrum of public and private leaders and stakeholders already providing or collaborating with HV programs throughout the state. The roster of members is included in this document as Appendix 1. The workgroup will continue to provide direction and oversight to implement and evaluate the

MIECHV Program in collaboration with the Home Visiting Task Force, Home Visiting Advisory Committee, partners and stakeholders.

Step two of the three step application process was the completion and submission in September 2010 of *Florida's Maternal, Infant and Early Childhood Home Visiting Needs Assessment.* On February 8, 2011, HRSA released the third and final step of the application process, a Supplemental Information Request (SIR) detailing the elements required in the Updated State Plan. This document, *Florida's Maternal, Infant, and Early Childhood Home Visiting Updated State Plan,* complies with the federal requirements under the ACA by providing the following information:

- Identifies at-risk communities in the state according to federal criteria;
- Describes the communities' plans to implement three evidence-based programs to serve pregnant women, infants and children in those communities;
- Describes Florida's plan to implement and administer the MIECHV Program statewide; and
- Identifies strategies to measure the benchmarks.

INTRODUCTION

The intent of the new federal legislative initiative is to establish evidence-based HV programs grounded in empirical knowledge throughout the nation, set high standards, provide states with technical support and guidance from HRSA and ACF, and hold states accountable for program implementation and the achievement of program benchmarks. The program allows for continued experimentation with new HV models that have demonstrated measurable success, and promotes a nationwide effort to develop comprehensive systems in every state that support pregnant women, parents or other caregivers, and young children, in order to maximize the likelihood of lifelong health and well-being, regardless of individual challenges or societal context.

As a key strategy for identifying and serving families at risk, the HV program fosters widespread collaboration among leadership in the fields of maternal and child health, early learning, and child protection. This strategy will prove beneficial in engaging Florida's large and diverse population. The legislation encourages and promotes the strengthening of partnerships among the federal government, states, local communities, HV program developers, and other stakeholders who are committed to serving the needs of pregnant women, infants, and young children, particularly young families who are among the most vulnerable in our society.

FLORIDA'S DEMOGRAPHICS

Florida has the fourth largest population in the United States, estimated at nearly 19 million for 2011 by the U.S. Census Bureau, and comprising 6% of the total U.S. population of 307,006,550. Since 2000, Florida has grown 16% compared to the national rate of about 9%, adding approximately 2.6 million residents, despite a decline in the growth rate since 2005. Its residents are among the most culturally diverse in the nation, with about 18.7% born in foreign countries, compared to 12.5% across the nation. More than one in five Florida residents are Hispanic/Latino and over 15% are Black, compared to the U.S. rates of 15.1% and 12.3%, respectively. By 2030, Hispanic and Black populations are projected to comprise about 43% of the state population, a significant increase from the current 35% rate. More than one in four residents five years of age or older, reside in homes where a language other than English is spoken, while just over one in 10 meet that criterion at the national level. The state's public education system identifies 200 first languages other than English spoken in the homes of students.

Florida's Demographics

- **Estimated 2011 Population: 8,878,541**
- **Births (2009): 221,391**
- **Children Ages 0-6: 1,591,292**
- **Race/Ethnicity**
  - **White (non-Hispanic): 59%**
  - **Black (non-Hispanic): 16%**
  - **Hispanic 22%**
  - **Other: 3%**

Source: Florida CHARTS

FLORIDA'S RANKING ON NATIONAL INDICATORS OF NEED

National data related to the health status of pregnant women, infants, and children serve as a benchmark of child well-being and provide a framework for comparing the relative success of each state in providing services to families at risk of adverse maternal and child health outcomes. One source for this type of data is Florida KIDS COUNT, part of the national KIDS COUNT Network sponsored by the Annie E. Casey Foundation, which aims to define and track children's quality of life indicators for policymakers as a catalyst for national discussion and action. The *2010 KIDS COUNT Data Book: A Florida Comparison* contains data for seven key indicators that closely relate to the stated purpose of the MIECHV Program and ranks Florida in the bottom half of all states on each indicator.

Florida's Ranking on Key Indicators

KEY INDICATORS	NATIONAL RANK
Percent low birth-weight babies	34th
Infant mortality rate	28th
Child death rate	27th
Teen birth rate	31st
Percent of children living in families where no parent has full-time, year-round employment	26th
Percent of children in poverty	27th
Percent of children in single-parent families	43rd

Source: 2010 KIDS COUNT Data Book: A Florida Comparison, Florida KIDS COUNT

The U.S. Variations in Child Health System Performance: A State Scorecard was published by the Commonwealth Fund Commission on a High Performance Health System. Although the data in their May 2008 report are not as recent (2001-2006) as the KIDS Count data, their 13 indicators encompass a broad range of issues related to the health of children: access (children uninsured), quality (children vaccinated, receiving medical/dental care, needing specialized care, etc.), costs (insurance premium costs, state health funding), equity (income, race/ethnicity, insurance coverage), and the potential to lead healthy lives (infant mortality, risk of developmental delay). Overall, Florida ranked in the bottom quartile of states across the 13 indicators, ranging from a low of 34 for costs to a high of 51 for access, and it ranked 50th in summary rankings of 51 jurisdictions including the District of Columbia. These findings cast a spotlight on Florida as a prime candidate for the initiation of state and federal programs and policies to improve health outcomes for children.

SECTION 1: IDENTIFICATION OF FLORIDA'S TARGETED HIGH-RISK COMMUNITIES

The first challenge for the workgroup was to identify the communities that would benefit most from the MIECHV programmatic funding.

IDENTIFICATION OF HIGH-RISK COUNTIES

As reported in *Florida's Maternal, Infant, and Early Childhood Home Visiting Needs Assessment,* 11 indicators were aligned to the eight benchmark domains specified in the legislation to select highest risk counties most in need of evidence-based home visiting services. Figure 1.1 shows these constructs and indicators.

County-level data were collected for each indicator and ranked using a methodology that involves averaging the ranks of the 11 indicators and sorting the counties in descending order by the average rank.

Figure 1.1

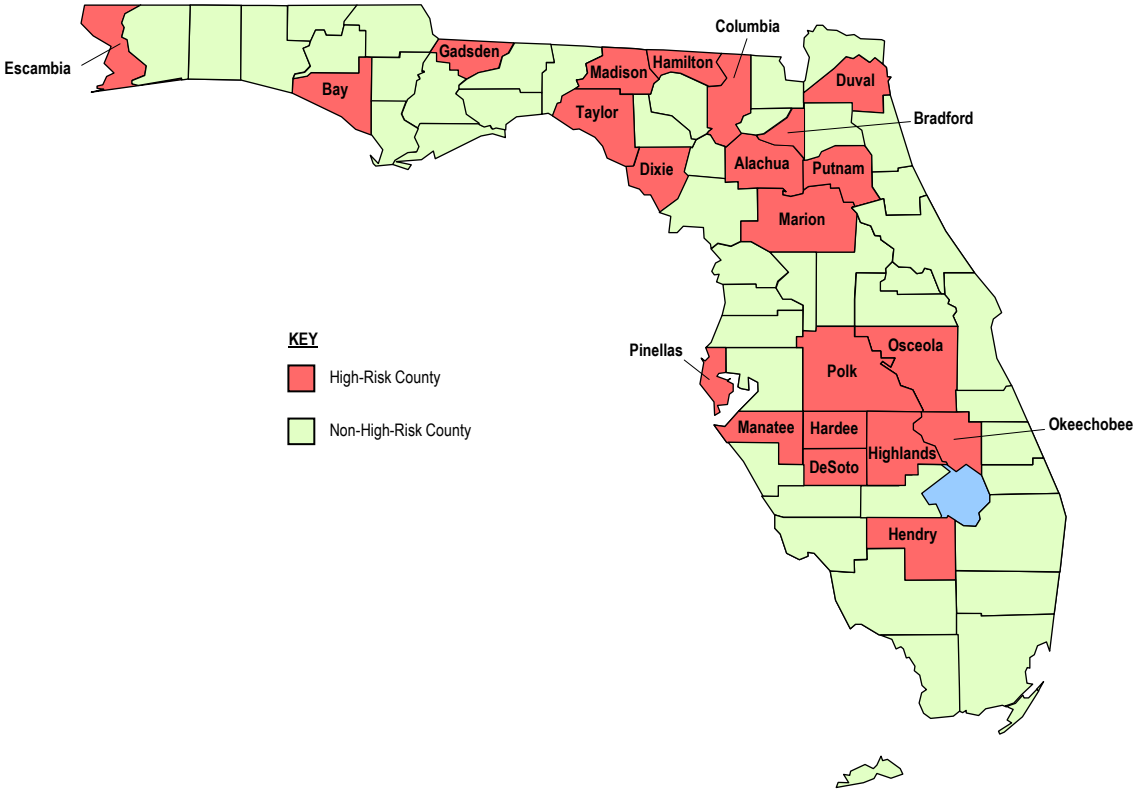
Florida's Needs Assessment: Constructs and Indicators

CONSTRUCTS	INDICATORS
Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health	***Premature Births*** **(Average 2006-08)** ***Low Birth-Weight Infants*** **(Average 2006-08)** ***Infant Mortality*** **(Death per 1,000 live births, Average 2006-08)**
Poverty	***Poverty*** **(Households with children ages 0-4 below 100 percent of the federal poverty level, Average 2006-08)**
Crime	***Index Crime per 100,000*** **(Average 2007-09)**
Domestic Violence	***Domestic Violence Offenses per 1,000*** **(Average 2007-09)**
High Rates of High School Dropouts	***High School Dropouts*** **(Average 2006-07 – 2008-09)**
Substance Abuse	***Substance Abuse Service Needs*** **(Ages 15-44, Average 2006-07 – 2008-09)**
Unemployment	***Unemployment*** **(Average 2007-09)**
Child Maltreatment	***Child Maltreatment Verified/Some Indications Findings*** **(Ages 1-4, Average 2007-09)**

Source: *Florida's Maternal, Infant, and Early Childhood Home Visiting Needs Assessment*

Based on the results of this analysis, the 22 counties, displayed in Figure 1.2 below, were identified as being high-risk communities. See Appendix 2 for the composite rank chart extracted from Florida's Statewide Needs Assessment.

Figure 1.2



IDENTIFICATION OF HIGH-RISK SUB-COUNTY AREAS

At the conclusion of the county-level analysis for the statewide needs assessment, the workgroup determined that an analysis at the sub-county level was necessary in order to create a more thorough and detailed needs assessment for a state as culturally and geographically diverse as Florida. Within highly-populated metropolitan counties that do not appear to be high risk according to the county-level data analysis, there could be many smaller communities with an intense need for interventions focusing on improving health outcomes for pregnant women, infants, and children. Thus, there was a great potential that pockets of critical need would be overlooked by county-level analysis. Because Florida has several highly-populated metropolitan areas, especially in the central to southern part of the state, a sub-county data analysis, at the census tract level, was conducted to identify pockets of high-risk areas.

Since sub-county data are not available for the indicators used to identity the counties most at risk, census data from the American Community Survey (ACS) for the years 2005-2009 were the best alternative for identifying areas of need at the sub-county level. Three indicators that

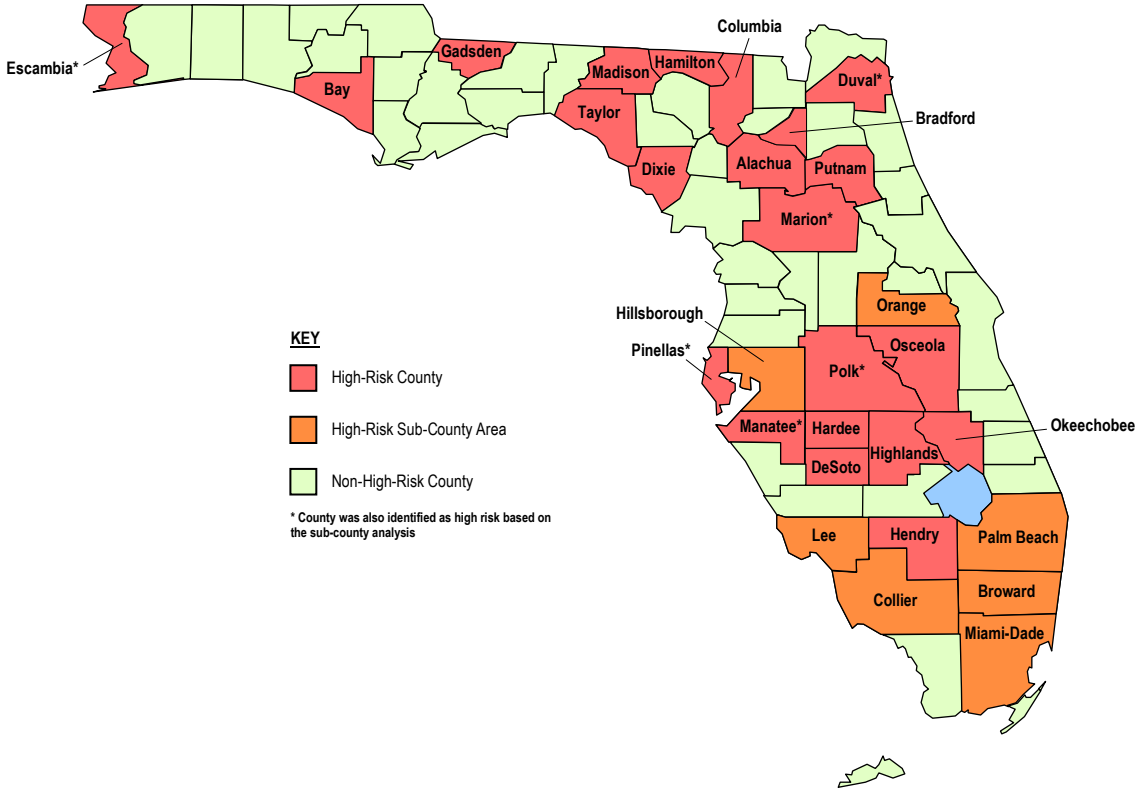
were available from the ACS were used in this analysis: 1) Percentage of persons, age 20 and above, in the labor force who are unemployed; 2) Percentage of persons, age 0 to 4, in families below poverty level; and 3) Percentage of persons, age 25 and over, with less than a high school education.

These three indicators were obtained from the U.S. Census Bureau website for the 3,154 census tracts in Florida. All of the census tracts were then ranked by the three indicators with high ranks indicating higher levels of need. The three sets of ranks were then added together to obtain a rank sum for each of the 3,154 census tracts. Using the rank sum, 20 percent of the census tracts with the highest rank sum were classified as the census tracts with the highest need.

The number of births below poverty level was estimated for each census tract by dividing the number of children ages 0 to 4 below poverty, by 5. These data were summarized by county by adding the estimated number of births in the top 20 percent high-risk census tracts for each county. Counties where the high-risk census tracts had more than 400 births below poverty level per year were classified as having the minimum number of potential home visiting clients in areas of high risk.

Thirteen (13) of the 67 counties were found to have census tracts in the top 20 percent of high risk and met the required number of births below poverty within those census tracts. Duval, Escambia, Manatee, Marion, Pinellas, and Polk were already identified as high-risk counties based on the original county-level analysis. Broward, Collier, Hillsborough, Lee, Miami-Dade, Orange, and Palm Beach were not previously identified as high-risk counties but due to the results of the sub-county census tract analysis, the workgroup classified these counties as having high-risk sub-county areas. Based on the county and the sub-county analyses, 29 of Florida's 67 counties were identified as high risk and classified as eligible to apply for the HV grants for the first year of funding. Figure 1.3 below displays all 29 identified counties.

Figure 1.3



SELECTION OF HIGH-RISK COMMUNITIES TO IMPLEMENT MIECHV PROGRAMS

Request for Application (RFA)

Adhering to Florida's procurement process, as established in Florida Statues, Chapter 287, requiring the procurement of services exceeding $35,000 must be achieved through a competitive solicitation; a Request for Application (RFA) was developed. The RFA was posted on DOH's Grant Funding Opportunities website on March 15, 2011 with an application deadline of April 22, 2011.

The RFA served two main functions relating to the SIR: to facilitate the requirement of the state to direct its resources to only those communities identified as high risk as a result of the Statewide Needs Assessment and to identify, at the local level, specific and crucial implementation characteristics of the high-risk communities and include that information in the development of the state plan.

Stipulations in the RFA specified that only the 22 high-risk counties and the seven high-risk sub-county areas meeting the minimum of 350 annual births below the federal poverty level requirement were eligible to apply for funding. In order to increase the likelihood of funding communities with the highest risk, identified high-risk counties not meeting a minimum number

of 350 annual births below the federal poverty level were permitted to partner with contiguous counties in order to meet the birth requirement, but a minimum of 60 percent of the qualifying births had to originate from the identified high-risk county. To further increase the likelihood of funding communities with the highest risk, points were allocated on a county's original standing in the Statewide Needs Assessment. Out of the 22 identified high-risk counties eligible to apply for funding, the counties ranking in the top seven, according to the Composite Rank in the Statewide Needs Assessment (refer to Appendix 2), received 100 points based on risk, while those ranked 8 – 14 received 50 points, and all others received zero points. This increased the overall chance that counties with the greatest risk received funding for home visiting services. In addition to awarding points to the counties with the greatest risk, the scoring criteria also included awarding points for those applicants specifying home visiting service provision would be geared toward the priority high-risk populations identified in Section 511 of Title V of the Social Security Act. These populations include eligible families who:

- reside in communities in need of such services, as identified in the statewide needs assessment;
- have low income;
- include pregnant women who have not attained age 21;
- have a history of substance abuse or need substance abuse treatment;
- have users of tobacco products in the home;
- are or have children with low student achievement; and
- include individuals who, are serving or formerly served in the Armed Forces, including such families that have a member of the Armed Forces who have had multiple deployments outside of the United States.

The second function of the RFA was to facilitate the identification of specific implementation characteristics of the high-risk community. The RFA required detailed information and submitted applications were scored on how well they addressed the following:

- Identification and description of the high-risk area and families;
- Identification of evidence-based home visiting model selected for implementation;
- Coordination and integration of community partners;
- Implementation plan for the proposed evidence-based home visiting model; and
- Capacity and capability to collect and report the required data.

The limited amount of funding in the first year of the grant made it crucial that the estimated three to six high-risk communities funded be best equipped to successfully implement a home visiting program and most capable of achieving the intended outcomes. Due to the geographic differences in population density and varying degrees of resources available within these geographic areas, the workgroup elected to fund at least one rural, one urban, and one metropolitan area with the first year of funding. In order to better direct efforts on establishing the administration and evaluation activities to implement a successful program a decision was made not to fund a promising practice model in the first year. The current uncertainty of future funding made it critical for Florida to attain the greatest benefit to cost ratio possible; however, in future years, the workgroup will reconsider including a promising practice model as an option.

Scoring and Selection of Communities for Implementation

Fifteen applications for funding consideration were received by the April 22, 2011 deadline. A team of five independent outsourced reviewers was selected to read and score all 15 applications based on pre-determined scoring criteria. The reviewers scored the applications without consulting one another. The scoring sheets were collected on May 5, 2011 and the workgroup met to average the scores and determine the communities to be funded. Table 1.1 depicts the five counties selected listed in order of scores received.

Table 1.1

County	Risk Score	Model Selected	Geographic designation	Implementing Agency	Number of clients to be served
Putnam Bradford	1 and 20	Parents as Teachers	Rural	Healthy Start of North Central Florida Coalition, Inc.	450
Escambia	3	Healthy Families Florida	Urban	Northwest Florida Comprehensive Services for Children (Families Count)	75
Duval	5	Nurse Family Partnership	Metropolitan	Northeast Florida Healthy Start Coalition, Inc.	120
Alachua	7	Parents as Teachers	Urban	Healthy Start of North Central Florida Coalition, Inc.	490
Pinellas	10	Parents as Teachers Plus	Metropolitan	Healthy Start of Pinellas County, Inc.	120

As shown in the table, with the exception of Bradford County, the counties selected were all in the top 10 highest risk counties. The highest three were from each of the geographic areas: rural, urban, and metropolitan.

DESCRIPTION OF IDENTIFIED AT-RISK COMMUNITIES

Each of the five selected areas is unique and represents the geographic and cultural diversity of the state. Interestingly, four of the five selected counties' are being implemented by Healthy Start Coalitions. The remaining area is administered by Families Count, a non-profit community agency.

The Florida Department of Health contracts with 33 Healthy Start Coalitions (HSC) that administer and implement the Healthy Start program throughout Florida. Coalitions conduct assessments of community needs and resources and provide community education and outreach activities aimed at helping pregnant women and infants access health care and reduce factors which could negatively impact birth and developmental outcomes. Healthy Start services are provided through contracts or memoranda of agreement between the Healthy Start Coalitions and private and public providers throughout the state.

Florida's Healthy Start Initiative was implemented in 1992 to reduce infant mortality, reduce the number of low birth weight babies, and improve health and developmental outcomes. In Florida, all pregnant women and infants are statutorily required to be offered screening for potential risks as soon as they enter the health care system. The screening instrument identifies risk factors based on medical, environmental, and psychosocial concerns (see Appendix 3 for tools).

Pregnant women are screened at their first prenatal appointment and infants are screened at the birthing facility based on information obtained from the birth certificate. Healthy Start services are available for all pregnant women and infants who are determined to be at risk for adverse health outcomes or who are referred due to special risk factors. The program is funded through general revenue and Medicaid.

Services are delivered according to state-adopted standards and guidelines by trained staff that includes nurses, social workers, and paraprofessionals based on program resources and family needs. Healthy Start home visiting services are complemented by specific risk reduction services including smoking cessation, psycho-social counseling, childbirth education, nutrition counseling, breastfeeding education and support, parenting and interconceptional education, and support. Services are provided on three (3) levels based on identified family risk factors.

- Level 1 clients receive services for 3 months with a minimum of one face to face visit.
- Level 2 clients receive services prenatally through age 3 with 2 contacts per month with a minimum of 1 face to face visit per month.
- Level 3 clients receive services for prenatal care through age 3 with 3 contacts per month with a minimum of 1 face to face per month.

The state Healthy Start program is considered a "promising practice", rather than evidence-based. In addition to being the primary mechanism for identifying Healthy Start clients, the universal screen also identifies clients in need of home visiting services in all Florida communities. Therefore, each of the implementing communities will also receive referrals for at-risk families from this Healthy Start screening process.

PUTNAM, BRADFORD, AND ALACHUA COUNTIES

This geographic area is in the north central part of the state and is generally considered a rural area. Putnam and Bradford Counties combined have 100,000 residents; Alachua County has nearly 250,000. The Healthy Start of North Central Florida Coalition (HSNFC) submitted two applications – one for Putnam and Bradford Counties as both were high-risk counties, but required partnering because neither had enough births below poverty to sustain a home visiting program. The two counties are marginally contiguous but are in the Coalition's normal 12-county

service delivery region and are considered to be a viable and feasible geographic area to serve. The HSNCF also submitted an application for Alachua County, another high-risk county that is in the service area. Alachua County sits just west and southwest of Putnam and Bradford, respectively.

Communities' Needs and Risk Factors

The risk indicators identified for Putnam, Bradford and Alachua Counties are in the table below.

Table 1.2

County	Premature Births	Low Birth Weight	Infant Mortality	Poverty	Crime	Domestic Violence	High School Dropouts	Substance Abuse	Unemployment	Child Maltreatment	
										Infants	0-4
Putnam **Measure**	13.7%	9.7%	7.6	39.3%	6052	12.0	4.0%	11.0%	8.0%	7.7%	6.0%
Rank	32	11	30	5	4	1	17	7	12	18	10
Bradford **Measure**	13.4%	9.5%	9.3	26%	2701	7	4.4%	10.9%	5.4%	5.7%	5.9%
Rank	43	13	13	35	48	21	10	34	57	42	14
Alachua **Measure**	13.6%	9.1%	8.3	22.4%	5082	6.8	2.7%	13%	4.8%	10.8%	5.2%
Rank	38	21	17	46	8	23	14	2	65	6	24

Note: *Rank 1 indicates highest need, rank 67 indicates lowest need.*

Composite rank for:
Putnam County = 1
Bradford County = 20
Alachua County = 7

With the exception of premature births, Putnam and/or Bradford counties are ranked in the highest risk tier (1 to 22) for all of the identified risk indicators. Not only are the composite rankings for these two counties in the highest risk tier, but Putnam County has been identified as the highest-risk county with a composite ranking of 1; Bradford County has a composite ranking of 20.

Except for premature births, poverty, domestic violence, unemployment, and child maltreatment, Alachua County is ranked in the highest risk tier (1 to 22) for all the identified risk indicators.

Low birth weight is identified as a risk indicator for Putnam and Bradford counties with rankings of 11 and 13, respectively. The average low-birth weight rates from 2006-2008 for Putnam County (9.7%) and Bradford County (9.5%) are higher than the state's rate (8.7%). Alachua County's risk indicator is 21. The average low-birth weight rate from 2006-2008 is 9.1%, which is higher than the state's rate of 8.7%.

Infant mortality is identified as a risk indicator for Bradford County with a ranking of 13. The average infant mortality rates from 2006-2008 for Bradford County (9.3 per 1,000 births) is higher than the state's rate (7.2 per 1,000 births). Alachua County falls in the bottom third with a risk indicator ranking of 17. The average infant mortality rate is 8.3 per 1,000 births, which is higher than the state's rate of 7.2 per 1,000 births.

From 2006-2008, the average rate of **children living in poverty** in Putnam County was 39.3%, ranking it as 5 for that risk indicator. Although Bradford County was not ranked in the highest risk tier for poverty, at 26.0%, the average rate of children living in poverty is still higher than the state's rate of 22.4%.

On average, the **index crime** rate for Putnam County from 2007-2009 was 6,052 per 100,000, resulting in a risk indicator rank of 4. Comparatively, Orange County with the highest rate of 6,202 crimes per 100,000 is only 128 greater than the Putnam County rate.

Alachua's **index crime** rate from 2007-2009 was 5,082 per 100,000, consequently resulting in a risk indicator rank of 8, which is higher than the state's rate of 4,587 per 100,000.

Putnam County ranks 1 for the **domestic violence** risk indicator. The average number of domestic violence offenses from 2007-2009 was 12.0 per 1,000, well above the number 2 ranked Gadsden County with 8.8 per 1,000, and almost twice that of the state's rate of 6.1 per 1,000. Domestic violence offenses are also identified as a high-risk indicator for Bradford County with a ranking of 21 and a rate of 7.0 per 1,000.

The **high school dropout** rate is identified as a risk indicator for all three counties – Putnam (17), Bradford (10), and Alachua (14), respectively. The average high school dropout rate from 2006-07 and 2008-09 for all three counties is around 4%, which is higher than the state's rate of 2.7%.

Alachua's **substance abuse service needs** rate is identified as a risk indicator with a ranking of 2. The substance abuse service needs rate from 2006-07 and 2008-09 is 13.1%, which is higher than the states rate of 10.3%. Putnam County ranked 7th with 11%.

On average, from 2007-2009 the **unemployment rate** for Putnam County was 8.0%, which gives it a risk indicator rank of 12.

The **infant maltreatment** rate in Alachua County rate is identified as a risk indicator with a ranking of 6 as the infant maltreatment rate from 2007-2009 is 10.8%, while Putnam County is ranked 7th with 7%, both of which are higher than the state's rate of 6.0%.

The **child maltreatment** rate for children ages 1 - 4 is identified as a risk indicator for both Putnam and Bradford Counties with rankings of 10 and 14, respectively. The average child maltreatment rates from 2007-2009 for Putnam County (6.0%) and Bradford County (5.9%) are both considerably higher than the state's rate of 3.8%.

Characteristics and Needs of Participants

Putnam County

The median household income for Putnam County is $33,812, which is below the state median income of $48,591. Nearly 31% of the county's children live in poverty, almost twice that of the state's rate of 17.6%. Overall, 15.8% of families and 52.6% of female-headed families live in poverty.

Teenage pregnancy is a critical problem in this county. Nearly 60% of all births are to unwed mothers, the fourth highest in the state. While the infant mortality rates slowly decreased in Putnam County, the disparity between white infant deaths and black/other infant deaths

continues to exist. Only 67% of pregnant women received prenatal care in the first trimester in 2009.

Bradford County

The median household income for Bradford County is $39,786, which is below the state median income of $48,591. Nineteen percent of the children live in poverty and nearly 40% of female-headed families live in poverty. The rate of births to unwed mothers in Bradford County is 53.6%, higher than the state's rate of 46.9%.

The infant mortality rates have continued to increase and so has the disparity between white infant deaths and black infant deaths. The black infant death rate (23.1 per 1,000) is almost four times greater than the white infant death rate (6.1 per 1,000). These disparities exist among infants born with low birth weight as well.

Alachua County

As stated previously, Alachua County ranks seventh in terms of need for home visiting services according to the Home Visiting Needs Assessment. Even though Alachua County is the home of the University of Florida and two large hospitals, the median household income is $38,512, which is below the state median income of $48,591. Nearly 23% of the county's population lives in poverty.

As indicated by these statistics, this three county area is in dire need of prevention and early intervention services. Of the 15 applications, that were submitted, the Putnam, Bradford area had the most indicators with the poorest rankings and they have the fewest resources.

Local Infrastructure

The Healthy Start Coalition of North Central Florida (HSNCF) is a private nonprofit organization that was incorporated in 1992 and it was one of the first Coalitions to exist in Florida. The HSNCF is the leader in maternal and child health care for North Central Florida and includes the following counties: Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Marion, Putnam, Suwannee, and Union. The HSNCF membership is made up of individuals from all 12 counties in the service area and represents advocacy groups, consumers of Healthy Start, local businesses, the education community, prenatal care providers, community health centers, local substance abuse services agencies, and many more. The HSNCF is responsible for bringing these individuals to the table to work together to improve the health and developmental outcomes for all pregnant women and children in the service area.

The HSCNF is made up of two key components: the Healthy Start Coalition and the Healthy Start Providers. The Coalition is responsible for:

- conducting assessments of community needs and resources;
- developing and implanting community-based services delivery plans;
- allocating public and private funds for prenatal care, child health care, and other Healthy Start services;
- ensuring a coordinated, integrated system of care;
- maintaining a resource directory for all prenatal and child health care in the services area;

- conducting community awareness and outreach activities aimed at helping more pregnant women and infants access health care;
- educating the medical community about its responsibility to encourage patient participation in Healthy Start services; and
- ensuring comprehensive prenatal and infant health care services are available and accessible.

HSNCF currently contracts with the Family Medical and Dental Center and the Bradford County Health Department to provide Healthy Start services in Putnam and Bradford Counties. The Alachua County Health Department provides Healthy Start services in Alachua County. These contracts will remain in place during the period of the grant and will be amended to include the responsibilities of providing evidence-based services of the selected model.

Healthy Start provides care coordination and services that support families in reducing the factors and situations that place pregnant women and infants in jeopardy for poor outcomes. The services offered by HSNCF include: outreach, care coordination, childbirth and parenting education and support, psychosocial counseling, tobacco education and cessation counseling, breastfeeding education and support, and interconceptional education, and counseling.

The HSCNF also has experience in facilitating and operationalizing broad community partnerships in its individual counties. One example of this is Putnam County's *Black Infant Healthy Practice Initiative.* Putnam County was one of eight Florida counties selected to participate in a project aimed at reducing black infant mortality. The Initiative was formed to determine factors associated with racial disparities in infant mortality, develop recommendations for improving health outcomes for black infants, and implement community-based interventions and policies. The HSCNF recruited over 60 community partners, raised the community's awareness of the problem, trained Initiative members to conduct focus groups, and developed recommendations for finding solutions to high infant mortality rates.

Existing Resources

Putnam County currently has three home visiting programs, Bradford County has two, and Alachua County has three. The table below outlines the type of program and initiative, the model used, the fidelity of that model to evidence-based practices, and the number of clients served.

Table 1.3

Putnam County			
#	Type of Program and Initiative	Curricula	Clients
1.	**Healthy Start:** comprehensive program promoting optimal prenatal health and developmental outcomes for all pregnant women and babies.	Florida's Healthy Start Parenting – Partners for a Healthy Baby	Prenatal = 656 Infant = 544 Total = 1,200
2.	**Healthy Families Florida:** strengthen families, promote positive parent-child relationships and optimize the health and development of children.	Growing Great Kids	100

3.	**Head Start/Early Head Start:** enhance children's physical, social, emotional and intellectual development; assist pregnant women to access comprehensive prenatal and postpartum care; support parents' efforts to fulfill their parenting roles; and help parents move toward self-sufficiency.	Parents as Teachers	15

Table 1.4

Bradford County			
#	Type of Program and Initiative	Curricula	Clients
1.	**Healthy Start:** comprehensive program promoting optimal prenatal health and developmental outcomes for all pregnant women and babies.	Florida's Healthy Start Parenting – Partners for a Healthy Baby	Prenatal = 215 Infant = 132 Total = 347
2.	**Healthy Families Florida:** strengthen families, promote positive parent-child relationships and optimize the health and development of children.	Growing Great Kids	25

Table 1.5

Alachua County			
#	Type of Program and Initiative	Curricula	Clients
1.	**Healthy Start:** comprehensive program promoting optimal prenatal health and developmental outcomes for all pregnant women and babies.	Florida's Healthy Start Parenting – Partners for a Healthy Baby	Prenatal = 1,590 Infant = 1,451 Total = 3,041
2.	**Healthy Families Florida:** strengthen families, promote positive parent-child relationships and optimize the health and development of children.	Growing Great Kids	180
3.	**Early Learning Coalition of Alachua County:** ensure that all young children living in the community receive the care and enriching learning opportunities they need to succeed in school and later in life.	Parents as Teachers	40

Healthy Start, Healthy Families, and Head Start/Early Head Start accept referrals from each other, as well as partnering community agencies such as Women, Infants and Children (WIC), Department of Children and Families (DCF), Partnership for Strong Families, and Community Partnerships for Children. Healthy Start also accepts self-referrals. All identified home visiting

programs provide care coordination and case management services, linking each family being served to other community resources as needed.

The primary referral resource for all three counties for the current home visiting programs is the Healthy Start universal screen as described earlier. Screening rates are closely monitored by HSNCF and trainings are regularly conducted with medical providers to ensure the screens are completed accurately. In the 2009-10 contract year, nearly 90% of all pregnant women and infants in Putnam and Bradford counties were screened. In Alachua County, 87% of all pregnant women and 97% of all infants were screened. Though a large majority of pregnant women and infants are screened, not all of those who could benefit from services consent to participate at the time of screening.

Local Coordination

Programs must rely on public awareness and community referrals to bridge this gap. While there is a system for referrals in place among various community organizations, it has become apparent during this application process that interagency communication can be improved. Local community programs need to develop a better understanding of the purpose and goals of those serving similar populations.

The HSCNF will form a home-visiting advisory group in each county to improve communication, reduce knowledge barriers, and consequently move toward a more formalized, systematic process for referrals. The initial membership will be composed of partners who have pledged support to this program through the letters of commitment and support. The group members and program staff will work together to identify additional key stakeholders, community leaders, and consumers to address the existing service gaps and needs of the families at risk for all three counties.

Letters of Commitment have been collected from identified local partners in each of the counties. All have agreed to collaborate and support efforts in providing services that meet the complex and diverse needs of families receiving home visiting services. These letters describe their role, assurance to collaborate, and commitment to enter into a Memorandum of Understanding with HSNCF within 90 days of the executed contract.

PINELLAS COUNTY

Pinellas County is a metropolitan peninsula of 24 cities located on the west-central coast of Florida. It is the most densely populated county in Florida, with 921,110 residents and includes 45,513 children under the age of five living in a 280 square mile area. There are more than 36,000 families with children under five years of age; one-third of them surviving below 185% of the federal poverty level.

Community's Needs and Risk Factors

The identified risks for Pinellas County are displayed below.

Table 1.6

County	Premature Births	Low Birth Weight	Infant Mortality	Poverty age 0-4	Crime	Domestic Violence	High School Dropouts	Substance Abuse	Unemployment	Child Maltreatment Infants	Child Maltreatment 1-4
Measure	12.9%	8.6%	8.4	21.6%	5114	8.3	2.5%	10.6%	7.0%	10.5%	5.1%
Rank	51	31	16	50	7	8	33	15	33	7	26

Note: *Rank 1 indicates highest need, rank 67 indicates lowest need.*

Composite rank for Pinellas County = 10

Pinellas County ranked tenth on the composite rank which means only nine counties had composite ranks that indicated a higher level of overall need than Pinellas County. The rates of infant mortality, crime, domestic violence, substance abuse, and child maltreatment for infants are all particularly high in Pinellas County.

Pinellas had the sixteenth highest **infant mortality** rate in the period 2006 – 2008. The rate of infant deaths per 1,000 live births in Pinellas, 8.4, was 17% higher than the statewide percentage of 7.2.

Pinellas had the seventh highest **crime** rate per 100,000 population in the period 2007 – 2009. The crime rate in Pinellas, 5114, was 11% higher than the statewide rate of 4587. Along the same vein, domestic violence is a serious problem in Pinellas with the eighth highest **domestic violence** rate per 1000 population in the period 2007 – 2009.

Nearly 11% of the infants in Pinellas have been reported as maltreated, 75% higher than the statewide rate of 6%. This county had the seventh highest **infant maltreatment** percentage for the period 2007 – 2009.

Pinellas ranks 10th overall on Florida's home visiting risk assessment indicators with social determinants of health including the most significant factors of infant mortality, substance abuse/misuse, child maltreatment of infants, crime, and domestic violence. An analysis of these risk assessment indicators demonstrates that substance abuse may be a root cause of many of the other risks to young families in Pinellas County.

Additionally, the District 6 (Pinellas-Pasco County) Medical Examiner Office annual Toxicology Report showed District 6 led the state in total deaths related to drug abuse/misuse. In 2008-09, the Circuit 6 Child Abuse Prevention and Permanency Plan reported over 11,000 serious findings of verified child abuse in Pinellas with the majority occurring in children 0-8 years old. Substance misuse by parents accounted for the great majority of abuse allegations (6,003) with 1,184 verified allegations of child abuse associated with substance misuse.

The 2010 unemployment rate in Pinellas was 12.4% (*Source: US Bureau of Labor Statistics), w*hich was 4.9% more than the previous year. The families in greatest need in Pinellas County are low income and have a history of substance misuse, need substance abuse treatment, or are at risk of involvement in the court system.

Characteristics and Needs of Participants

Many of the participants will meet the high-risk priorities identified in the legislation such as: low income families, pregnant women less than 21, users of illicit drugs and tobacco, and families with low school achievement. In particular, the target population will be pregnant women who misuse drugs and infants who have been exposed to drugs. While this project is limited to 120 families, the initial assessment period will identify further gaps in the system and allow for capacity building and strategic planning to provide an expanded system of care for young children at risk for maltreatment due to substance misuse. This process will be coordinated by a Home Visiting Advisory Committee whose members will include representatives from each of the home visiting programs and parent participants in Pinellas County.

Local Infrastructure

The Healthy Start Coalition (HSC) will serve as the lead agency for this project. The HSC was incorporated 19 years ago and has a history of collaboration in Pinellas County. The HSC has agreements and contracts with multiple health and human service organizations in Pinellas County and frequently leads in the planning of new Maternal Child Health programs and initiatives. Community-wide initiatives facilitated by Healthy Start Coalition staff include the Tobacco Free Coalition, Healthy Futures Perinatal Systems Improvement, Early Childhood Mental Health, Perinatal Loss Support Groups, the Uninsured Prenatal Care Task Force, Substance Exposed Newborn Task Force, Pinellas KidCare Coalition, and the Infant-Toddler Committee. The Healthy Start Coalition also provided leadership for a project to develop Pinellas Early Childhood Interagency Procedures. That two-year process gained consensus on collaborative procedures and produced an interagency agreement document signed by more than 20 child-serving agencies in Pinellas County.

Over the past 18 years, the Pinellas County Health Department (PinCHD) Central Registration has been the hub of the home visiting care system for pregnant women and children. Central Registration receives over 16,000 mandated Healthy Start Prenatal and Infant Screenings and triages over 3,116 high risk referrals for services annually. Participants are "searched" and registered in the computerized client information system, Health Management System (HMS), and assigned to one of the Pinellas Healthy Start Umbrella Programs based on eligibility criteria. Pregnant women and newborn infants are screened for Healthy Start risk factors and those who volunteer to receive home visiting services are assigned, by the PinCHD intake unit, to the most appropriate program based on their identified risks. Last fiscal year, 91% of all pregnant women and 98% of all newborn infants received a HS risk screening in Pinellas County. The Healthy Start system works closely with the DCF to help reunite children with their families and participates in the Safe Start Initiative to serve children 0-6 who have witnessed violence. An interagency agreement with 32 agencies includes use of a standard Pinellas referral form. Referrals are also received from community developmental screenings, held quarterly at three sites in Pinellas County, to identify children who may need services including home visitation.

Both the HSC and the PinCHD have demonstrated their capacity to implement a variety of home visiting programs, both evidence based and research based models. The HSC helped establish the current PAT home visiting team and provides home-based contracted services to Healthy Start clients. The HSC Coalition also contracts with care coordinators who provide

Healthy Start services in office-based settings. The proposed integrated system is shown in Appendix 5.

Existing Resources

Over the years, Pinellas has built a home visitation system of care for pregnant women and children that avoid duplication. The PinCHD plays a major role in providing home visiting services as the lead agency for Healthy Start, Federal Healthy Start and Healthy Families partnering with the Healthy Start Coalition of Pinellas, Juvenile Welfare Board, the Ounce of Prevention Fund of Florida, and a variety of physician practices and community agencies. During the calendar year 2010, 2820 pregnant women and infants were served through the home visiting programs in Pinellas County.

Table 1.7

Pinellas County			
#	Type of Program and Initiative	Curricula	Clients
1.	**Even Start:** literacy curriculum and instructional support system for children in preschool, kindergarten and first grade, and their families and teachers	Parents as Teachers	45 Families
2.	**Healthy Start:** comprehensive program promoting optimal prenatal health and developmental outcomes for all pregnant women and babies.	Florida's Healthy Start Parenting – Partners for a Healthy Baby	119 Individuals
3.	**Pinellas Early Head Start:** assist pregnant women to access comprehensive prenatal and postpartum care; support parents' efforts to fulfill their parenting roles; and help parents move toward self-sufficiency.	Parents as Teachers	38 Families
4.	**HIPPY:** home based family-focused program model that helps parents support the development of their preschool children	Age Appropriate HIPPY Series	175 families
5.	**Early Steps**: provides initial screening and developmental evaluation if needed	Individualized Family Support Plan (IFSP)	N/A
6.	**Florida First Start**	Not Specified	130 children

7.	**Healthy Families Florida:** strengthen families, promote positive parent-child relationships and optimize the health and development of children.	Growing Great Kids	1125
8.	**Healthy Families Plus:** strengthen families who are using or abusing substances, promote positive parent-child relationships and optimize the health and development of children.	Growing Great Kids	515 families
9.	**St. Petersburg Federal Healthy Start**	Florida State University's Partners for a Healthy Baby Parents as Teachers	119 women

The Healthy Start Federal Project is part of the National Healthy Start Initiative funded by the HRSA. This program is currently serving 119 at risk individuals, such as, African-American, prenatal, interconceptional women, and infants in four zip code areas of St. Petersburg. Healthy Start consists of three multi-disciplinary (nurses, paraprofessionals, social workers, etc) teams in south, mid, and north Pinellas County. Curricula currently being used by Healthy Start include the Florida State University's (FSU) Partners for a Healthy Baby and the PAT curriculum.

The Healthy Families Program utilizes the "Growing Great Kids" curriculum. Pinellas Healthy Families, accredited by Healthy Families America, has a total of 15 home visiting teams providing county-wide services and includes three teams serving women and infants identified as having problems with substance use. During FY 2009-2010, Healthy Families Plus (HF+) served 515 families experiencing substance abuse issues. However, due to their eligibility criteria, HF+ is unable to accept infants over 3 months of age or families involved in the child welfare system into their program. This creates a need and gap in intensive specialized services in Pinellas County.

Referral resources currently available and needed in the future include 256 community organizations and resources. A Resource Guide to the myriad of services in Pinellas County is updated, printed, and disseminated quarterly. The 211 hotline is also utilized to identify community resources. Current home visiting service providers actively refer participants to these community resources. In 2010, PinCHD home visiting programs made 2168 referrals for community services. The highest number of referrals for infants was for substance use and it is the fourth highest referral for pregnant women. Additional resources for substance using women and their children will be sought. Initial contacts have been made with Pinellas Schools for adult literacy wrap around services and WorkNet Pinellas for job opportunities and job counseling.

Local Coordination

During this application process, multiple organizations were engaged to plan how to address the existing service gaps and needs of this target population in Pinellas County. In addition to the primary partners previously listed, the following organizations were identified as having resources that might meet the needs of the families at risk.

Mental and Behavioral Health Services -– WestCare Gulf Coast-Florida, Inc. (West Care) is a family of tax-exempt non-profit organizations providing a wide spectrum of human services in both residential and outpatient environments. Services include a juvenile justice treatment program, drug court, outpatient counseling and substance abuse treatment.

Central Florida Behavioral Health Network (CFBHN), operates 24 mental health and substance abuse providers in nine counties, including Pinellas, providing publicly funded behavioral health services. In Pinellas, the main providers are Directions for Mental Health, Inc.; Operation PAR (PAR); PEMHS; Suncoast Center for Community Mental Health; ACTS; and Boley Center for Behavioral Health Care. The Pinellas drug court has agreed to make referrals to the PAT+ home visiting program. Operation PAR and Westcare will also refer clients in outpatient treatment who are pregnant or have young children.

Child Care and Early Learning Support – The Coordinated Child Care of Pinellas (CCC) assists low and middle income families to pay for child care. The Early Learning Coalition of Pinellas, Inc. is an administrative and planning entity, which disseminates federal funding to community partners that provide child care. They also coordinate community developmental screening for young children. Subsidized child care referrals will also be offered to PAT+ participants.

The JWB Children's Services Council (JWB) is the nation's first countywide agency using dedicated property tax revenue to fund community-based programs for children and families. The JWB is a major funder of the PinCHD's Healthy Families program and has agreed to provide subsidized childcare for 25-30 children of PAT+ clients.

Health – Pinellas County Health Department (PinCHD) is the primary source of maternal child health (MCH) data for community-based agencies and will provide oversight of data related to the PAT+ program. The PinCHD serves as the lead agency for the majority of the home visiting programs in Pinellas. The SEEK team will provide vision and hearing screening for children in Pinellas. The PAT+ team will become the preferred program for drug-using women and drug-exposed infants who are involved in the child welfare system and drug-exposed children who are older than 3 months and ineligible for HF+.

A new Home Visiting Advisory Committee, with representation of all the home visiting programs and clients of the home visiting programs, will be established and will meet quarterly to improve coordination of home visiting services for families and the community. By sharing resources and coordinating training, home visiting services throughout the community will be improved.

Letters of Commitment from community partners mentioned above have been collected and a Memorandum of Understanding (MOU) with committed partners will be obtained within 90 days of contract execution. Letters of support indicate services to be provided to families including:

adult literacy, job training, doula services, playgroups, subsidized child care and drug treatment to help families become self-sustaining with PAT program assistance.

ESCAMBIA COUNTY

Escambia is the westernmost county in Florida and borders Alabama and Georgia. It is considered an urban county with just over 300,000 people living within the 2000 square mile area. This panhandle region is not as ethnically diverse as the central and southern areas of the state, with only 7% of the population being of foreign background.

Community's Needs and Risk Factors

Table 1.8

County	Premature Births	Low Birth Weight	Infant Mortality	Poverty age 0-4	Crime	Domestic Violence	High School Dropouts	Substance Abuse	Unemployment	Child Maltreatment	
										Infants	1-4
Measure	16.7%	10.7%	8.6	28.6%	4877	8.4	3.2%	11.6%	6.5%	6.3%	3.2%
Rank	3	6	15	26	9	5	25	3	40	34	58

Note: *Rank 1 indicates highest need, rank 67 indicates lowest need.*

Composite rank for Escambia County = 3

Escambia County ranked third on the composite rank which means only two counties had composite ranks that indicated a higher level of overall need than Escambia County. The rates of premature birth, low birth weight, infant mortality, crime, domestic violence, and substance abuse were all particularly high in Escambia County.

Babies being born too early is a serious problem in Escambia County, as it had the third highest **premature birth** percentage in the period 2006 – 2008. The percentage of premature births in Escambia, 16.7%, was 17% higher than the statewide percentage of 14.2%. Going hand in hand with the high premature birth rate, Escambia had the sixth highest **low birth weight** percentage in the same period. The percentage of births below 2500 grams in Escambia, 10.7%, was 23% higher than the statewide percentage of 8.7%.

Escambia had the fifteenth highest **infant mortality** rate in the period 2006 – 2008. The rate of infant deaths per 1000 live births in Escambia, 8.6, was 19% higher than the statewide percentage of 7.2.

The **crime rate** in Escambia, 4877, is the ninth highest crime rate per 100,000 population in the period 2007 – 2009. Concurrently, Escambia had the fifth highest **domestic violence** rate per 1,000 population at 8.4, and was 36% higher than the statewide rate of 6.1.

Substance abuse for adults plagues Escambia with the third highest substance abuse percentage for population age 15 to 44 in the period 2006 – 2009. The percentage in Escambia, 11.6%, was 13% higher than the statewide rate of 10.3%.

Characteristics and Needs of Participants

Escambia County is the 19th poorest county in the United States where 16% of the population is poor and 23.1% of the children live in poverty.

Local Infrastructure

Families Count, a non-profit community agency, currently holds the contract with the Department of Children and Families in partnership with the Ounce of Prevention Fund for the Healthy Families program in Escambia and Okaloosa Counties. The Healthy Families Florida program provides home visiting services in three high-risk zip codes in Escambia County. Families Count has provided quality services and fiscal responsibility since 1999. In order to reduce costs, virtual offices with state of the art technology were created for the Family Support Worker positions last year. This same strategy will be duplicated for the expanded program in Escambia County.

Families Count will continue to facilitate the Healthy Kids/Healthy Families Advisory Board with a seamless transition, meeting monthly with all the partners integral to helping high-risk families and children.

Existing Resources

Escambia County has five (5) programs with home visiting components: Healthy Families, Head Start, Early Head Start, Healthy Start, and Parents as Teachers.

Table 1.9

Escambia County			
#	**Type of Program and Initiative**	**Curricula**	**Clients**
1.	**Healthy Start:** comprehensive program promoting optimal prenatal health and developmental outcomes for all pregnant women and babies.	Florida's Healthy Start	600-700 Children and Pregnant women
2.	**Healthy Families Escambia:** dedicated to improving early childhood outcomes by preventing child abuse and neglect.	Healthy Families America	52 Families
3.	**Head Start:** provides comprehensive education, health, nutrition, and parent involvement services to low-income children and their families	None Specified	855 Children
4.	**FRAME:** early childhood parent education program that focuses on positive child development	Parents as Teachers	112 Families
5.	**Early Head Start:** promotes healthy prenatal outcomes for pregnant women, enhances the development of very young children and promotes healthy family functioning in low-income families	None Specified	70 Children; 10 Pregnant women

Healthy Start, a program of the Escambia County Health Department, provides targeted support services. Healthy Start serves all of Escambia County and has approximately 600-700 pregnant

women and children being served on a monthly basis. The Healthy Start Coalition and the Department of Health monitor the program annually.

Healthy Families Escambia is a program of Families Count and currently provides services in the 32505, 32506 and 32507 zip codes of Escambia County according to a prescribed leveling system. Healthy Families Escambia is accredited by Healthy Families Florida and Healthy Families America.

Escambia Head Start, a program of the Community Action Partnership provides comprehensive education, health, nutrition, and parent involvement services to low-income children and their families. Family advocates focus on healthy development for children ages three (3) to five (5), work with low-income parents, and assist parents in accessing community resources. The Head Start Policy Council (comprised of parents and community representatives) is responsible for the annual self-assessment of fiscal and programmatic operations. The program is also monitored every three (3) years by the Federal Head Start Program. Eligibility is largely income based. Children with disabilities must make up at least 10% of those served. There are 855 children enrolled in Head Start and there is a waiting list. Families are required to receive two (2) home visits from the teacher and one (1) from the family advocate but may receive as many as are needed to help the family.

FRAME uses the Parents as Teachers (PAT) program as an early childhood parent education program that focuses on positive child development by providing home visits and group meetings. PAT uses trained parent educators to work with families with children who have not yet entered school. Families receive bi-weekly home visits. Monthly parenting groups are provided; parents are provided transportation and childcare in order to encourage attendance. One hundred and twelve (112) families are currently served. PAT serves families residing in the attendance areas for the eight (8) highest poverty elementary schools in Escambia County.

Escambia Early Head Start Program, also a program of the Community Action Partnership, promotes healthy prenatal outcomes for pregnant women, enhances the development of very young children, and promotes healthy family functioning in low-income families. Services are provided through home-based and center-based programs. Center-based families are required to receive two (2) home visits from the teacher and one from the family advocate but may receive as many as are needed to help the family. Home-based families receive weekly visits from the family advocate. Services may continue until the child reaches three (3) years of age.

Local Coordination

There are a number of agencies that currently coordinate and collaborate to provide services to families in need. The MOUs will continue or be renewed with:

- Children's Medical Services of Northwest Florida
- The Community Action program (Healthy Start/Early Head Start)
- Shelter House
- The Vision Council (Infant Mental Health)
- Lakeview Center, Inc.
- The Early Learning Coalition of Escambia County
- Families First Network
- Florida KidCare

- The Department of Children and Families for Food Stamps Medicaid and TANF
- Baybridge Insurance Company
- Community Drug and Alcohol Council Women's Intervention Services Education Program
- Escambia County Healthy Start Coalition
- Families First Network (CBC)
- Florida KidCare
- Sacred Heart Hospital and the Early Steps Program
- The Florida Department of Children and Families
- The University of West Florida
- University of Florida IFAS Extension
- ECARE (reading)
- The Escambia United Way 211 system
- Community Action Head Start Program
- Escambia County Health Department Healthy Start Program
- Escambia United Way 211 System
- Favor House of Northwest Florida
- Pregnancy Resource Center of Pensacola
- The Alpha Center
- The PAT Program
- The Vision Counsel (Infant Mental Health)

DUVAL COUNTY

Duval County is unique in that the city of Jacksonville and the county consolidated governments in 1968, making it the largest city in area in the continental United States, covering 841 square miles. It is a rapidly growing metropolitan city in Northeast Florida, with approximately 850,000 residents.

Community's Needs and Risk Factors

Table 1.10

County	Premature Births	Low Birth Weight	Infant Mortality	Poverty age 0-4	Crime	Domestic Violence	High School Dropouts	Substance Abuse	Unemployment	Child Maltreatment	
										Infants	1-4
Measure	14.7%	9.5%	9.4	20.3%	6195	8.2	4.4%	10.4%	6.9%	6.9%	4.0%
Rank	15	14	12	59	2	9	11	26	35	28	41

Note: *Rank 1 indicates highest need, rank 67 indicates lowest need.*

Composite rank for Duval County = 5

Duval County ranked fifth on the composite rank which means only four counties had composite ranks higher than Duval County. The rates of premature birth, low birth weight, infant mortality, crime, domestic violence, and high school dropout were all particularly high in Duval County.

Duval County had the fifteenth highest **premature birth** percentage in the period 2006 – 2008, with 14% of all babies born premature. The county ranked similarly with the fourteenth highest

low birth weight percentage in the period 2006 – 2008. Nearly 10% of births weighed less than 2500 grams.

Infant Mortality rate in the period 2006 – 2008 was 12th in the state. The rate of infant deaths per 1000 live births in Duval, 9.4, was 30% higher than the statewide percentage of 7.2.

The **crime** rate in Duval County is the second highest crime rate per 100,000 population in Florida for the period 2007 – 2009. The crime rate in Duval County, 6,195, was 35% higher than the statewide rate of 4,587.

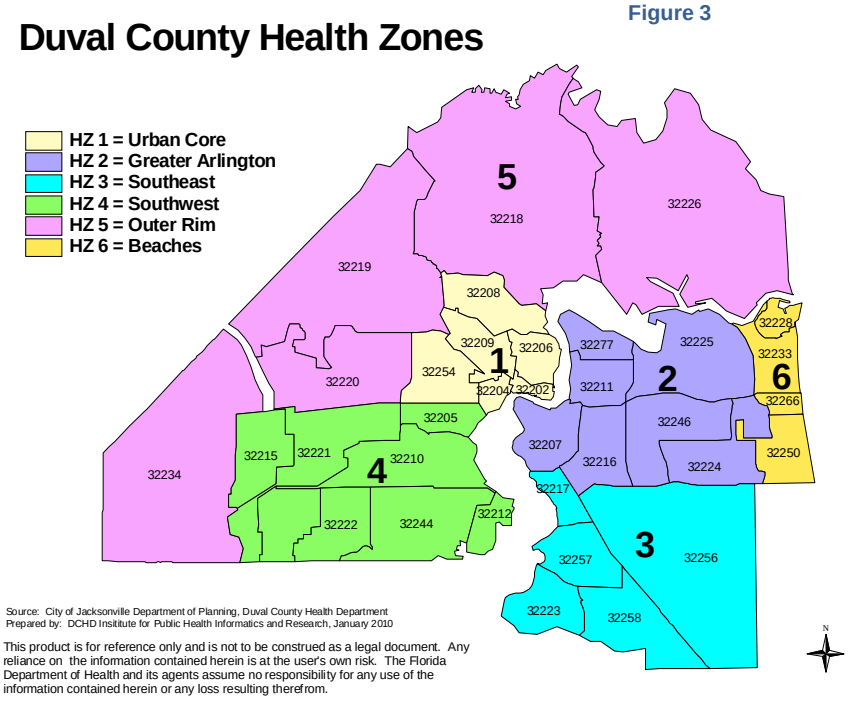
This county had the ninth highest **domestic violence** rate per 1000 population in the period 2007 – 2009. The 8.2 domestic violence rate in Duval County was 34% higher than the statewide rate of 6.1.

For a metropolitan area, Duval County's **high school dropout** percentage was the 11th highest for the period 2006 – 2009. The percentage in Duval County, 4.4%, was 63% higher than the statewide rate of 2.7%.

Identification and Description of At-Risk Area and Families

The county has an average of 13,460 births annually (2007-09). More than 40% of these births are to first-time mothers while 18% of all births are below 100 percent of the federal poverty level (2,450). Three sub areas of the city will be given priority for enrollment: the New Town Success Zone and surrounding community (Health Zone 1), Greater Arlington (Health Zone 2), and Westside/SW (Health Zone 4).

Figure 3



An area of dire need is the New Town Success Zone (NTSZ), a neighborhood-based City Initiative modeled after the Harlem Children's Zone. The need for a home visiting program is specifically identified in the strategic plan developed by the NTSZ Early Childhood Subcommittee in 2010. The goal of the NTSZ is to develop a continuum of services for children and their families prenatally through pre-college that contribute to their health, safety, and educational success.

Community's Needs and Risk Factors

Edward Waters College, the oldest Historically Black College and University in Florida, is the organizational home of the NTSZ initiative, which is directed by a community steering committee

and subcommittees focusing on early childhood, health, education, and economic development. The NTSZ is a major asset for this area and the surrounding community (Health Zone 1).

Health Zones 2 and 4 represent tipping point neighborhoods characterized by growing pockets of poverty and other social risk factors, particularly in zip code areas proximate to the city center. These areas have a significant number of births to teen mothers, low school attainment, and high tobacco use. Unlike Health Zone 1, however, these areas have access to a wider array of resources from affordable housing, to health clinics, grocery stores, Title I schools, and neighborhood organizations. The population is more diverse (about one-third Black compared to 85% Black in Health Zone 1) and includes concentrations of Hispanics and other ethnic groups.

Local Infrastructure

The Duval Healthy Start Coalition is responsible for the planning, funding, and oversight of the largest voluntary home visiting program in the county. More than 8,900 pregnant women (80%) and 5,120 families with newborns in Duval County received some level of services from Healthy Start in 2009-2010. In Duval County, Healthy Start services are provided through a collaborative, multi-agency model. This model channels families at varying risk to the agency best equipped to address their needs. Need is determined based on Healthy Start screening scores and individual assessments. Home visiting services range from low-intensity - provided by the Children's Home Society - to moderate and higher intensity services through the Duval County Health Department (DCHD) and Shands Jacksonville. The collaborative, multi-agency model has had a direct and measurable impact on birth outcomes in Duval County; infant mortality has significantly declined over the last five years, reaching its lowest level in more than a decade.

The Duval County Health Department (DCHD), as a public health leader for in the community, is both an experienced partner and advocate for implementation of evidence-based models. The DCHD has a history of successfully implementing home-based public health interventions, and is currently active in the implementation of selected health education models focused on reproductive health and improved health outcomes. The health department's 2011-13 Strategic Plan has identified these key outcome improvement priorities: infant mortality, immunizations, unintended pregnancies, and teen births. The health department operates a network of community-based clinics that provide prenatal, pediatric, family planning, sexually transmitted infections (STI) testing and treatment, and primary care services to Medicaid and low-income residents. A new DCHD strategy which combines STI and family planning programs is being tested to maximize efforts for better results. The DCHD's commitment to maternal and child health (MCH) workforce competency and community partnerships makes the department a critical partner in the NFP initiative with the Coalition and Shands Jacksonville.

The Coalition is proposing to implement the NFP using a multi-agency team comprised of the DCHD and Shands Jacksonville. This approach complements and strengthens the city's current continuum of home visiting services by expanding the services offered by the agencies currently responsible for delivering the most intensive (Level III) Healthy Start services. One of the strengths of the NFP team (DCHD and Shands Jacksonville) is its direct access to many health, social, and support services that will be needed by participating families. These include primary

and specialty care for women and children, WIC, immunizations, family planning, psycho-social counseling, injury prevention and environmental health programs. As a public health agency and university-affiliated teaching hospital, they also have access to complementary resources and funding streams that will contribute to the sustainability and expansion of NFP.

The Duval County Health Department and Shands Jacksonville have the capacity, experience, and commitment needed to successfully implement a nurse-delivered, intensive intervention to first-time mothers living in high-risk communities in Jacksonville. Inter-agency coordination of the NFP team will be assured through the active involvement of a Leadership Team representing MCH executive staff in the participating organizations.

Existing Resources

This table summarizes the continuum of home visiting services currently available to families in Duval County; Appendix 6 has a more detailed table showing the models used, intensity and fidelity, and clients served by the programs.

Table 1.11

Duval County			
#	Type of Program and Initiative	Curricula	Clients
1.	**Healthy Start:** comprehensive program promoting optimal prenatal health and developmental outcomes for all pregnant women and babies.	Florida's Healthy Start Parenting – Partners for a Healthy Baby	5,748 Annual participants
2.	**Federal Healthy Start:** Magnolia Project	Not Specified	130
3.	**Healthy Families Florida:** strengthen families, promote positive parent-child relationships and optimize the health and development of children.	Growing Great Kids	935
4.	**Family Support Services:** provide safety, stability, and quality of life for all children by working with the community to strengthen the family unit	Not Specified	TBD
5.	**Head Start/Early Head Start:** enhance children's physical, social, emotional and intellectual development; assist pregnant women to access comprehensive prenatal and postpartum care; support parents' efforts to fulfill their parenting roles; and help parents move toward self-sufficiency.	Parents as Teachers	15

Duval County's multi-agency system of home visiting services is driven by the Healthy Start prenatal and infant screens. This well-established, comprehensive screening process allows families to be referred to service providers in the community who are most appropriate to their needs. Healthy Start screens are completed by prenatal care providers and by hospitals following delivery and sent to the Regional Processing Center at the Duval County Health Department. The screens are triaged to specific agencies based on screening score, risk factors, and an initial assessment. Triage criteria are determined annually through a coordinated process based on agency capacity, resources and eligibility criteria.

This centralized intake and triage process is monitored at monthly meetings of the Duval County providers, which is chaired by the Healthy Start Coordinator at the health department. Follow-up mechanisms are in place to ensure referrals are timely and appropriate. Processes are also in place to facilitate transfer of participants between agencies following initiation of care if different needs are identified at in-take.

In addition to administering the state Healthy Start program, the Coalition has been proactive in developing and implementing community-based initiatives to meet identified needs. In 1999, it received federal Healthy Start funding for the Magnolia Project, an innovative preconception intervention to address health disparities in infant mortality. The project provides home visiting, education, and support to 130 high-risk women of childbearing age annually. Services are delivered by paraprofessional staff supported by a nurse and social worker. The project includes an on-site women's health clinic operated by the DCHD. A new adolescent health clinic is being piloted at the site offering education and family planning services to teens twice a month. The Magnolia Project serves Health Zone 1, which has the highest African-American infant mortality in the county. A longitudinal evaluation funded by the Centers for Disease and Control and Prevention, demonstrated the positive impact of project services on subsequent birth outcomes.

Healthy Families Jacksonville (HFJ) is the second largest home visiting initiative in Duval County, reaching over 900 participants annually. HFJ uses the evidence-based Healthy Families America home visiting model to provide education and support to families at-risk of child abuse and neglect. Funded by the Jacksonville Children's Commission and Florida Healthy Families, the program is delivered by two community-based organizations (the Bridge of NEF and Community Connections) in specific zip codes of the county. Home visiting services are provided by specially-trained paraprofessionals using a structured curriculum. HFJ maintains strict adherence to a staffing, supervision, and programmatic model. The program experienced both state and city funding cuts over the last two years, contributing to reductions in service area and the number of families served (-100). HFJ functions as an integral part of the city's home visiting continuum. Eligible families are identified based on responses to specific questions included on the state Healthy Start prenatal screen and the program participates in monthly meetings of county Healthy Start providers.

The newest home visiting programs for the MIECHV target population in Duval County are Early Head Start and Family Support Services. Early Head Start is provided by the Jacksonville Urban League (New Town and zip code 32209) and Episcopal Children's Services (selected at-risk areas). Both programs were established in 2010 with new federal funding from the ACF. The programs follow the evidence-based Early Head Start home visiting model and serve a limited

number of pregnant women and newborns in low-income families. Trained paraprofessionals provide parent support and education on child development using an approved curriculum. Both programs use a combination home-and center-based model. The Jacksonville Urban League's Early Head Start program includes a new center on the campus of Edward Waters College, established as part of the New Town Success Zone initiative.

Additional Services

Substance-involved pregnant and parenting women and their families receive home visiting through the Azalea Project. The project model was originally developed in 2003 with funding from the federal Substance Abuse and Mental Health Services Administration. It focuses on women who are at risk for a poor birth outcome, as well as sexually transmitted infections (STI) and the *human immunodeficiency virus (HIV),* because of their involvement with drugs and alcohol. The Azalea Project is supported by state Healthy Start and City funding, as well as federal pass-through dollars to provide services for high-risk women in the criminal justice system. The Azalea Project is comprised of para-professional staff that is supported by a Healthy Start nurse out-posted at the project site. Two of the project staff are employees of Gateway Community Services, a substance abuse treatment program that offers specialized services for pregnant and parenting women. The Azalea Project augments home visiting services with group education and support based on a life-course approach. The project also facilitates access to testing for STIs and treatment through a new collaboration with the health department that places an advanced registered nurse practitioner at the site two days a week. An evaluation of the Azalea Project documented the program's success in delivering intensive education and support to high-risk participants, improving birth outcomes and reducing risk-taking behavior that contributes to recidivism and STIs/HIV.

The Coalition's newest initiative is the Camellia Project, which provides education and support to mothers who have had a loss or a baby hospitalized in the neonatal intensive care unit. Funded by the Florida March of Dimes, the project completes an initial assessment during a home visit. Services are primarily delivered through groups to build interdependence and support among participants. The goal of the project is to reduce identified risks and improve health behaviors that might affect a subsequent birth outcome in this high-risk population. The three-year pilot includes a comprehensive evaluation of the project's impact on knowledge, self-efficacy, and behavior change.

The Coalition and its network of Healthy Start providers have an established relationship with Naval Hospital Jacksonville (NAS Jax). More than 700 military families residing in Duval County deliver at the hospitals annually. NAS Jax provides prenatal care at the hospital and a community clinic at the Mayport Naval Air Station. These facilities completed Healthy Start prenatal screens on nearly 350 pregnant patients in 2009. Shands Jacksonville is the hospital of choice for high-risk obstetrics and neonatal care. NAS Jax is also an active participant in the NE Florida Breastfeeding Collaborative, an initiative working to improve breastfeeding support through the implementation of the Baby-Friendly Hospital Initiative.

Local Coordination

The Nurse Family Partnership program will be fully integrated into the existing continuum of home visiting services in Duval County, allowing it to take full advantage of the well-established referral arrangements required to meet the complex needs of participating families.

Combining the assets of the University of Florida (UF) and Shands HealthCare, Shands Jacksonville offers more than 70 specialty services on-site and through a network of community clinics, including women's health, obstetrics, pediatric and primary care. The hospital provides Level III NICU care, as well as specialty services for HIV-affected families as part of the Ryan White program. Nearly 4,000 pregnant women deliver at the hospital annually; most of their prenatal care is provided by UF obstetricians and health department clinics. Shands Jacksonville and its Little Miracles program have provided clinic and home-based Healthy Start services since 2001. Located in Health Zone 1, UF and the hospital offer community-responsive services through the Jacksonville Urban Disparity Initiative with a goal of addressing health disparities in neighborhoods surrounding the hospital.

The current MCH coordinating group will form the foundation for the MIECHV-required home visiting advisory council. Membership will be expanded to include additional key community partners that provide referral services, as well as parents.

Letters of Commitment and support from key partner organizations in the community have been obtained. Ongoing collaborations, formal Memoranda of Understanding (MOUs) and reciprocal referral arrangements with these agencies will ensure services are available to address the MIECHV benchmarks and constructs. Although policies prevented NAS Jax from providing a letter of commitment and support, the military base re-iterated its interest and willingness to work with the Coalition and other community partners in providing services to families. Required Memoranda of Understanding (MOUs) will be secured by the Coalition with partner agencies in the community within 90 days of program funding. MOUs will outline each partner's role, how services will be coordinated and integrated for NFP participants, data collection strategies, evaluation role and participation in the home visiting advisory group as needed.

SUMMARY OF IDENTIFIED AT-RISK COMMUNITIES

In summary, the counties that were selected to implement the MIECHV program services are clearly among the most at risk in the state and will benefit greatly from the services offered by the variety of home visiting models. It is also evident that each of the communities garnered support from the local community-based agencies to ensure successful implementation of the programs in their areas. It is Florida's intent to renew the contracts with each of the five communities on an annual basis provided the state, federal, and program model requirements are met and funding is available.

SECTION 2: FLORIDA'S HOME VISITING PROGRAM GOALS AND OBJECTIVES

Child health and developmental outcomes depend to a large extent on the capabilities of families to provide a nurturing, safe environment for their infants and young children. Unfortunately, many families have insufficient knowledge about parenting skills and an inadequate support system of friends, extended family, or professionals to help with or advise them regarding child rearing. Home visiting programs offer a mechanism for ensuring that at-risk families have social support, linkage with public and private community services, and ongoing health, developmental, and safety education. When these services are part of a system of high-quality well-child care linked or integrated with the pediatric medical home, they have the potential to mitigate health and developmental outcome disparities.

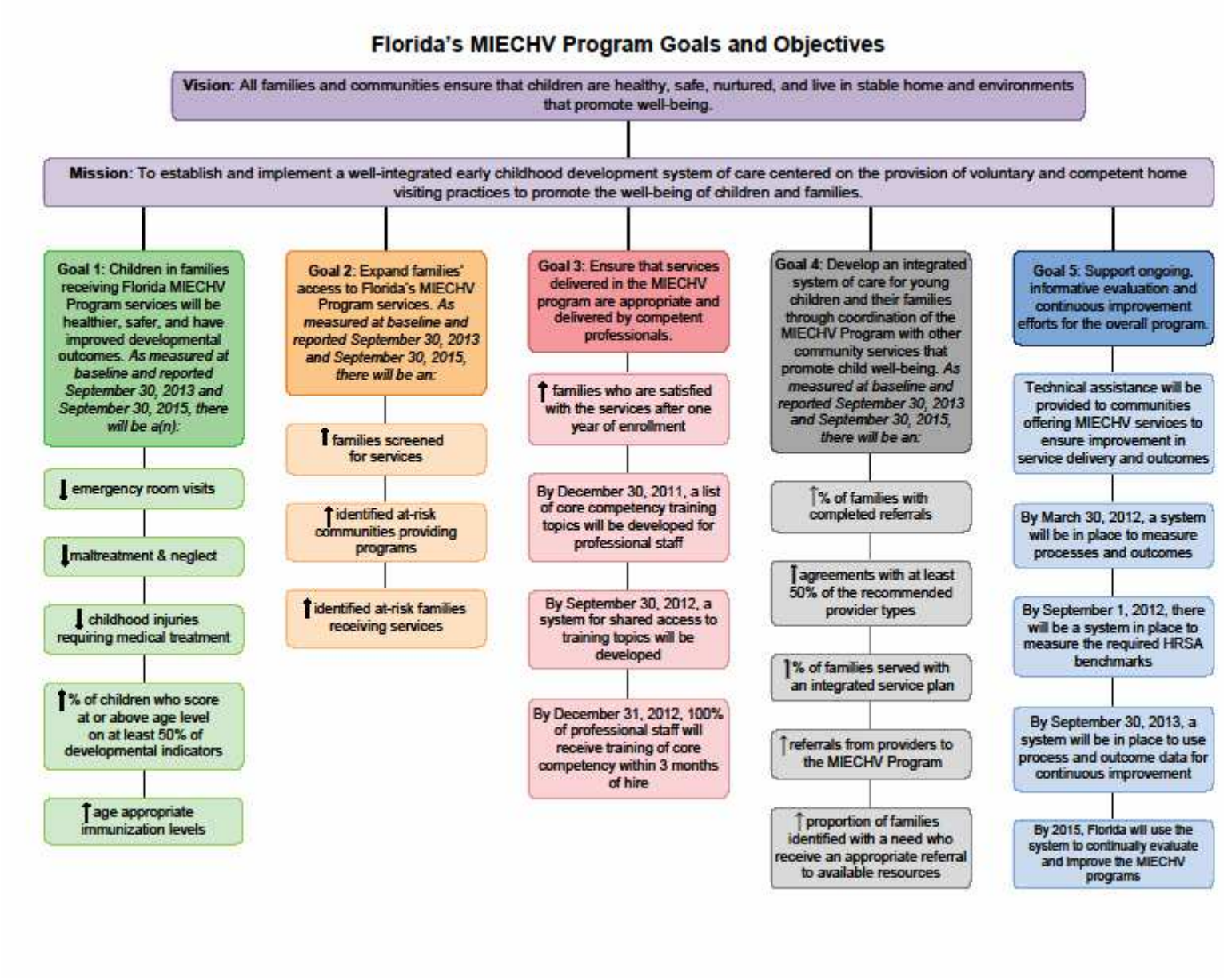
The purpose of Florida's Home Visiting Program is to serve these most vulnerable families and children – families who reside in the poorest of communities; have young mothers; are living in violent homes; are struggling with substance abuse, mental health, and disability concerns; and are ill-equipped to encourage healthy physical, emotional, and cognitive development. The provision of services to these families should be informed by the life course approach to meeting a family's needs through provision of integrated services, as this perspective underscores the interplay of how risk and protective factors, such as socioeconomic status, health behaviors, environment, stress, and education, influence health and development throughout one's lifetime. Therefore, the vision for the MIECHV Program is that *all families and communities ensure that children are healthy, safe, nurtured, and live in stable homes and environments that promote well-being.*

It is Florida's intent that communities should work together to leverage existing resources in order to provide peripheral services that the primary home visiting program does not directly provide. These would include services for substance abuse and mental health counseling, early education, child care assistance, utilization of a family's natural supports in the community, and referrals to other community resources that the family may need to improve their immediate situation.

Collaboration with existing home visiting programs as well as other early education childcare and social service programs is paramount to serving families in need. Creating a system of care for families who are in need of pre and post–natal care as well as support for early childhood care and education is a vital undertaking for the state of Florida. This concept summarizes the mission of the Program: *to establish and implement a well-integrated early childhood development system of care centered on the provision of voluntary and competent home visiting practices to promote the well-being of children and families.*

Although there are a range of different models, the typical home visitation program uses home visiting as the primary strategy for the delivery of services to families. These services can include providing information about parenting and child development, home safety, and referrals to appropriate community resources.

Florida recognizes that each evidence-based home visiting model has its own goals and objectives developed to meet the model's intent. Implementing multiple models in the state requires a broader range of goals and objectives to incorporate all of the specified models' purposes. To this end, the Departments have determined the following goals and objectives for the statewide MIECHV program. Should new information arise that suggests a need for a revision of the initial goals and objectives, the workgroup in collaboration with partners and stakeholders will address it appropriately to ensure accountability to the MIECHV Program.


Florida's MIECHV Program Goals and Objectives
Vision: All families and communities ensure that children are healthy, safe, nurtured, and live in stable home and environments that promote well-being.
Mission: To establish and implement a well-integrated early childhood development system of care centered on the provision of voluntary and competent home visiting practices to promote the well-being of children and families.
Goal 1: Children in families receiving Florida MIECHV Program services will be healthier, safer, and have improved developmental outcomes. As measured at baseline and reported September 30, 2013 and September 30, 2015, there will be a(n):
↓ emergency room visits
↓ maltreatment & neglect
↓ childhood injuries requiring medical treatment
↑ % of children who score at or above age level on at least 50% of developmental indicators
↑ age appropriate immunization levels
Goal 2: Expand families' access to Florida's MIECHV Program services. As measured at baseline and reported September 30, 2013 and September 30, 2015, there will be an:
↑ families screened for services
↑ identified at-risk communities providing programs
↑ identified at-risk families receiving services
Goal 3: Ensure that services delivered in the MIECHV program are appropriate and delivered by competent professionals.
↑ families who are satisfied with the services after one year of enrollment
By December 30, 2011, a list of core competency training topics will be developed for professional staff
By September 30, 2012, a system for shared access to training topics will be developed
By December 31, 2012, 100% of professional staff will receive training of core competency within 3 months of hire
Goal 4: Develop an integrated system of care for young children and their families through coordination of the MIECHV Program with other community services that promote child well-being. As measured at baseline and reported September 30, 2013 and September 30, 2015, there will be an:
↑ % of families with completed referrals
↑ agreements with at least 50% of the recommended provider types
↑ % of families served with an integrated service plan
↑ referrals from providers to the MIECHV Program
↑ proportion of families identified with a need who receive an appropriate referral to available resources
Goal 5: Support ongoing, informative evaluation and continuous improvement efforts for the overall program.
Technical assistance will be provided to communities offering MIECHV services to ensure improvement in service delivery and outcomes
By March 30, 2012, a system will be in place to measure processes and outcomes
By September 1, 2012, there will be a system in place to measure the required HRSA benchmarks
By September 30, 2013, a system will be in place to use process and outcome data for continuous improvement
By 2015, Florida will use the system to continually evaluate and improve the MIECHV programs

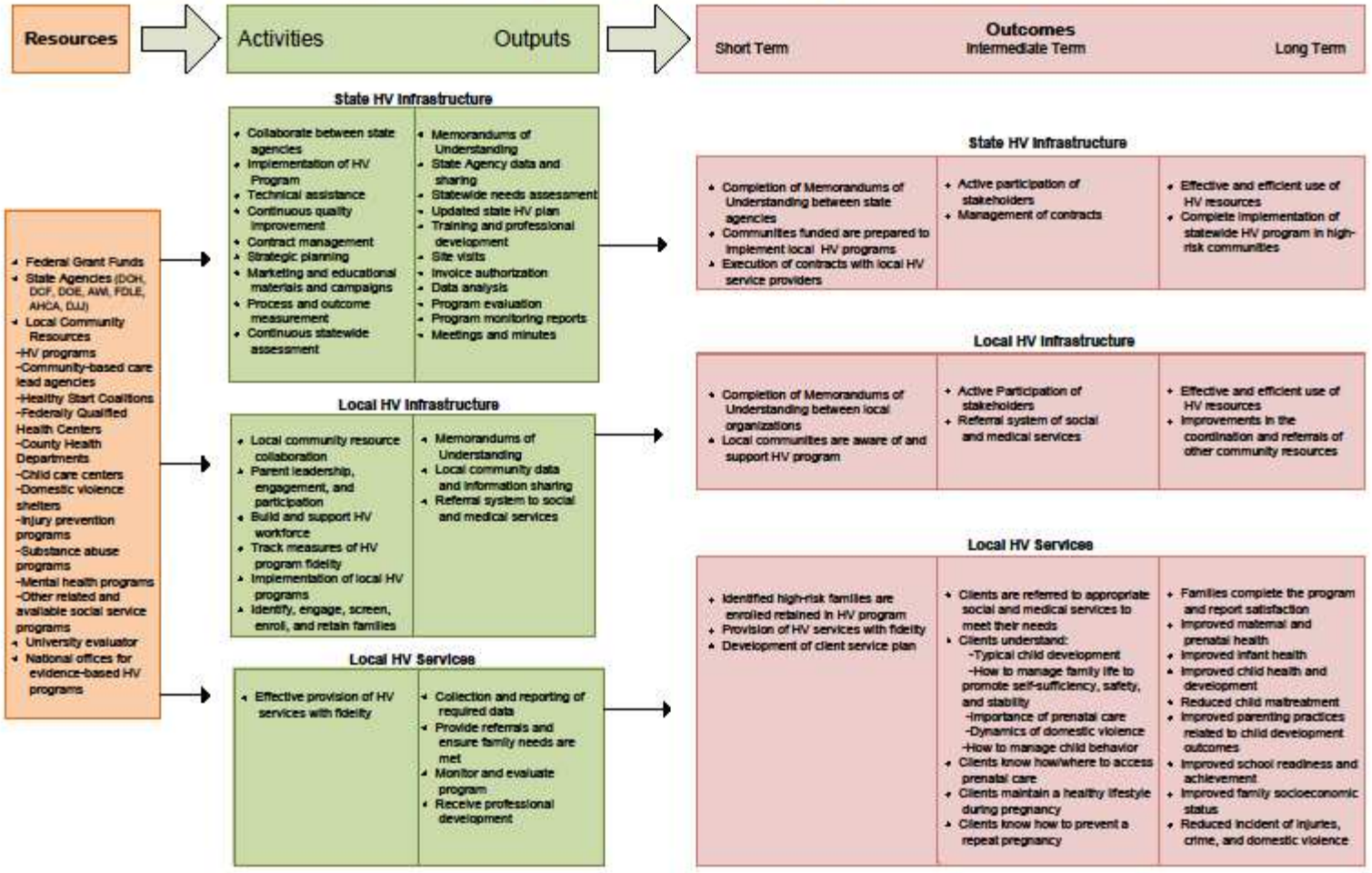
Recognizing that formulating and articulating a logical process to identifying resources needed to implement a successful MEICHV Program was essential to a viable state plan, the workgroup developed a logic model. It was determined that the overall goals of the program will be achieved as a result of three distinct program components: state infrastructure; local infrastructure and the local home visiting services themselves. The state's goals and objectives are incorporated in the logic model.

The logic model will be used as a tool to monitor Florida's progress toward achieving the goals and objectives. Should new information arise that suggests a need for a revision of the initial model, the workgroup in collaboration with partners and stakeholders will address it appropriately to ensure accountability to the MIECHV Program.

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Logic Model

Program Population: Pregnant women and their families in high-risk communities; children ages 0-8 and their families in high-risk communities

Assumption
Pregnant women and young children have a complicated yet important set of needs. Research has shown that evidence-based home visiting programs can provide services to meet these complex and diverse needs.



SECTION 3: SELECTION OF HOME VISITING MODELS AND EXPLANATION OF HOW THE MODELS MEET THE NEEDS OF IDENTIFIED COMMUNITIES

Section 2 describes the competitive process used to select the five communities to implement the MIECHV services. This section describes the evidence-based models selected and how the model chosen best serves the identified needs of their communities.

DESCRIPTION OF MODELS FOR INITIAL IMPLEMENTATION

Three of the five chosen applicants chose to integrate the Parents as Teachers (PAT) model into their existing Healthy Start program. Healthy Families Florida and Nurse Family Partnership were the other two models selected. To avoid duplication in the subsequent sections, a brief description of each model is provided.

Parents as Teachers

Parents as Teachers is an evidence-based home visiting program that serves a broad spectrum of families with high needs and offers services from the start of prenatal care through the child's entry into kindergarten. Grounded in the latest research, the PAT curriculum supports a parent's role in promoting school readiness and healthy development of children, including prevention of abuse and neglect. A PAT-certified Parent Educator uses the Parents as Teachers Foundational curriculum and an overlay of wrap around services**.** This curriculum helps parents understand their role in encouraging their child's development, helps prepare their children for school and life success and is administered in four components: 1) Personal home visits: including in-home assessments, development of therapeutic alliances with participating families and helping parents/caregivers learn meaningful parental/family functioning skills; 2) Parent meetings (group connections), during which parents meet to share their experiences and gain new knowledge; 3) Screenings of children's development, health, hearing and vision; and 4) Referrals to community resources. PAT programs have been recognized as a proven intervention for supporting parents in reducing child abuse and neglect. PAT outcomes are: improved maternal and prenatal health, improved child health and development, improved positive parenting practices related to child development outcomes, improved school readiness, reduction in child maltreatment, and reduction in incidences of family violence and crime.

The Parents as Teachers 2011 training, curriculum, and logic model revisions include a deepened focus on building evidence-based Strengthening Families™ Protective Factors, addressing family well-being topics, and promoting children's health and safety. Parents as Teachers increases protective factors and reduces risk factors associated with child abuse and neglect. Parents as Teachers is also listed as a supported evidence-based program in Community-based Child Abuse Prevention's (CBCAP) evidence-based and evidence-informed programs. As described later, Florida's CBCAP Program is currently working to infuse the Strengthening Families™ Protective Factors into all of Florida's home visiting programs. Florida is fortunate that PAT has a statewide coordinator based in Tampa who provides support and

training to all new and established PAT programs. This coordinator will assist the new programs to implement the model successfully.

Healthy Families Florida

The Healthy Families Florida (HFF) program, a CBCAP grantee, is one of the three selected models for implementation and is accredited by Healthy Families America (HFA), an evidence-based, nationally accredited, voluntary HV program of Prevent Child Abuse America. HFF serves as an accredited Central Office to provide critical functions such as training, quality assurance, technical assistance and ongoing evaluation and quality improvement to ensure model fidelity and quality in all affiliated programs in Florida. This Tallahassee based office will oversee any Healthy Families programs that are awarded MIECHV Program funding.

As the single largest funded voluntary child abuse and neglect prevention program in Florida, HFF is a program utilizing home visitation, education and support groups, as well as promotion of and access to health care systems. HFF is designed to enable children to grow up healthy, safe and nurtured by promoting positive parenting and healthy child development. HFF offers expectant families and families of newborns experiencing stressful life situations and poor childhood outcomes (as determined by a voluntary assessment) home visiting services from trained family support workers. Families are also linked to a medical provider and other family support services they may need, such as substance abuse treatment, mental health counseling, education, training, job services, and child care. Services may begin prenatally or within the first three (3) months after the child's birth and may continue until the child enrolls in an early education program or turns five (5) years of age, with the intensity and duration based on each family's needs.

Nurse Family Partnership

Nurse-Family Partnership (NFP) is an evidence-based community health program which provides first time, low-income mothers with home visitation services from public health nurses. NFP's goals are to improve pregnancy outcomes by helping women engage in good preventive health practices; improve child health and development by helping parents provide responsible and competent child care; and improve the economic self-sufficiency of the family by helping parents develop a vision for their own future.

Nurse-Family Partnership is a national program currently operating in 28 states and 163 sites. Services start at 12-28 weeks of gestation and continue on an intensive schedule of visits until the target child is two years of age. Research shows that the impacts of implementing the Nurse-Family Partnership with fidelity include: improved prenatal health; fewer childhood injuries; fewer subsequent pregnancies; increased time between births; increased maternal employment and improved school readiness.

PUTNAM, BRADFORD, AND ALACHUA COUNTIES

While Healthy Start of North Central Florida (HSNCF) is a long-standing program and has well established processes for service delivery, the current parenting education model is not evidence-based. HSNCF has been actively seeking means to replace the current parenting curriculum with an evidence-based model and is ready to move toward implementation. The

evidence-based home visiting model that best meets the needs of Putnam, Bradford and Alachua Counties is Parents as Teachers (PAT). The HSNCF will also provide PAT training to Healthy Start staff in order to switch the current non-evidence-based curriculum *Partners for a Healthy Baby* to one that has been proven effective. This will allow for the PAT curriculum to be used throughout the 12 county service area and build sustainability for the program in future years.

WORKING WITH THE NATIONAL MODEL DEVELOPER

The Parents as Teachers National Center, Inc. is a not-for profit organization that provides PAT training and technical assistance, certification for PAT parent educators, curriculum and materials development, research and evaluation coordination and international conferences.

All service providers who will deliver PAT services, as well as supervisors, will attend the Foundational and Model Implementation Trainings. Furthermore, service providers will have access to competency-based professional development and training and will recertify with the national office annually. Within the first year, service providers will be required to have 20 hours of professional development. In year two, 15 hours of professional development will be required. Thereafter, 10 hours of professional development are required annually.

The PAT State Office Supports Florida PAT Programs by coordinating trainings, providing technical support, publishing newsletters, advocating for the program, and collaborating closely with other home visiting programs. The HSNFC will avail themselves to both of these entities for assistance in implementing the model successfully and with fidelity.

MODEL FIDELITY AND QUALITY ASSURANCE

Research shows that positive outcomes are the result of interventions that are faithful to the model. Based on best practices used in the field of early childhood home visitation, Parents as Teachers National Center has developed and tested eight standards and quality indicators. These standards cover the four service delivery components of the PAT model along with four additional areas of program implementation. Each of the eight areas is supported by a set of indicators that specify the criteria and quality implementation of the model. The following are the eight "Parents as Teachers Standards" that must be followed to ensure quality and fidelity of the program.

1. **Personal Visits** support parents in their parenting role in order to promote optimal child development and positive parent-child interaction.
2. **Group Meetings** provide opportunities for parents to acquire information about child development, parenting, and positive parent-child interaction while gaining support from each other.
3. **Screening** provides regular information about each child's health and developmental progress; increases parents' understanding of their child's development; and identifies strengths and abilities, as well as areas of concern.
4. **Resource Network** connects families to needed resources and takes an active role in the community, establishing ongoing relationships with other institutions and organizations that serve families.

5. **Recruitment and Retention** promote services in the community, recruits and promptly serves the maximum number of eligible families, and facilitates families' ongoing participation in services.
6. **Program Management** program is carefully designed, well managed and efficiently operated, incorporating ongoing planning and review of the program implementation.
7. **Professional Development** supports the professional growth of all staff and increases staff competency in delivering services to children and families.
8. **Evaluation** reflects the program's accountability for effective program implementation and outcomes for the children and families served.

PAT provides quality assurance guidelines for PAT affiliates. The HSNCF recognizes that in order to optimize short and long-term objectives, faithfulness to the model as tested with rigorous impact research is essential. To best serve the needs of their clients, HSNCF will ensure that program fidelity is maintained throughout the program by providing services as outlined by the PAT program and through continuous QA/QI processes. Services will address all four of PAT's major program components and remain faithful to the program's core values as it is described in PAT's logic model.

Additionally, PAT has a program self-assessment tool that HSNCF will utilize. The program self-assessment guides a program in evaluating the degree to which it fulfills the PAT standards and quality indicators. Self-assessment plays a critical role in providing useful, timely and meaningful information about how well a program is implemented. By completing the self-assessment, parent educators increase their ability to provide optimal services to children and families in the community. The self-assessment process helps programs: 1) increase collaboration, communication and learning among staff and community members; 2) affirm and highlight program strengths; 3) produce a manageable, high-quality plan to further strengthen services; 4) demonstrate accountability and promote continuous quality improvement; 5) contribute to each parent educator's annual re-certification; and 6) earn recognition from PAT National Center.

The HSNCF has an ever-evolving systematic process for addressing continuous quality improvement that includes quarterly chart reviews; reports from the service providers; annual site visits and chart audits by HSNCF. Healthy Start has over two decades of providing home visiting services. Consequently, the infrastructure for supporting the PAT model is already established.

As previously discussed, the PAT model is well-suited for easy integration into the state's Healthy Start model and infrastructure, this includes quality assurance practices. For example, the Healthy Start model already includes six out of the 12 components outlined by the PAT Quality Assurance Guidelines and HSNCF will integrate the other six components within the first year of implementation.

ANTICIPATED CHALLENGES

PAT and the state's Healthy Start Program share a common goal in that both strive to improve outcomes for children and their families. While the adoption of PAT may improve the Healthy Start program as a whole, there are challenges that may need to be addressed.

Transportation is particularly difficult for rural residents in all three counties who may not have reliable transportation and where public transportation is limited or non-existent. Additionally, the high cost of gas and the long distances some clients may be required to travel to receive certain services also pose considerable challenges. Travel assistance such as gas cards will help to increase attendance at group meetings. Efforts will be made to ensure group meetings are scheduled at a convenient, central location for clients.

Anticipated Challenges

- Client transportation
- Capturing data
- Accommodating the higher level intensity of the PAT model

The health management system (HMS) is currently used by the Healthy Start program to collect public health service and time data as well as program reporting data. It is inherently beneficial to have this system for data collection in place prior to the implementation of the PAT program. However, some modifications to the HMS system will be necessary in order to easily track data specific to the PAT program. The HSCNF will also work with the evaluation team to collect data and use standard assessment tools.

Additionally, because the evidence-based PAT model requires a higher level of intensity in the provision of services, a more defined timeframe for providing instructions to the home visitors, and more preparatory work on the front-end of each service, the change to an evidence-based model will require acceptance from both staff and administration. Many Healthy Start providers have been using the same non-evidence-based parenting education component for years. Buy-in will be achieved through education and discussion about using research-based practices to improve outcomes. Current service providers will also need to balance their caseloads while being trained in the PAT program. Advanced notice of training dates will assist service providers in scheduling efforts.

Once resources are available, additional staff will be hired to reach greater numbers of clients in need of home visiting services. Through the longstanding 12 county-wide network of community organizations, service providers, and the Healthy Start Coalition, qualified staff recruitment will be possible.

Beyond the required PAT foundational and model implementation trainings, Healthy Start staff may require technical assistance in the application of evidence-based practices, performance indicators, service coding, and charting requirements.

PINELLAS COUNTY

The Pinellas County social services community recognizes the need for specialized, effective, home visiting services for families with substance misuse issues. Community partners have applied for other grants to serve this population in the past in order to build the system of care

and capacity to meet the needs. In May 2010, a group of community leaders including, the Healthy Start Coalition (HSC), WestCare, Juvenile Welfare Board (JWB), Pinellas Schools System, the Court of the Sixth Judicial Circuit, the Pinellas Sheriff's Office, and the Pinellas county health department (PinCHD) held two planning sessions to discuss ways to improve services and outcomes for drug-using families of young children. Parents involved in the Pinellas Adult Drug Court were asked to list critical services that their families would most benefit from in the areas of learning, living, and playing/working. The results of the surveys and meetings were used in writing this application.

In February 2011, the Planning and Evaluation Committee of the Healthy Start Coalition met to review the Florida Home Visiting Assessment results and considered each evidence-based home visiting (EBHV) option to identify the most relevant evidence-based curriculum to meet the identified needs of the community. Because of the benchmarks impacted and the risk factors in Pinellas County, the Healthy Families America model was initially selected. However, the existing Healthy Families program in Pinellas County is not at full capacity because the eligibility criteria for Healthy Families excludes substance exposed families involved in the child welfare system and substance exposed infants older than 3 months of age. This leaves an important identified gap in services. Based on the identified risk indicators and a gap analysis of existing home visiting programs, Parents as Teachers Plus (PAT+) was selected as the model to serve the substance exposed families in Pinellas County. Wrap around services will be added to the curriculum to best meet the needs of these identified families.

The PAT model was successfully integrated into the Healthy Start program in June 2010 indicating that it is feasible and viable to provide that evidence-based program and meet the Healthy Start standards and guidelines effectively. In Pinellas County, Even Start has successfully used the PAT model since 1997 and will be resource. The new PAT+ Team would consist of four certified PAT staff from the existing program (3 parent educators and supervisor). Appendix 5 shows the staffing infrastructure for effectively implementing PAT+.

There are no adaptations to the PAT evidence-based home visiting model planned. The national office of Parents as Teachers has approved Healthy Start's plan to serve drug using women using their curriculum and to provide additional wrap around services.

WRAP AROUND SERVICES

Pinellas County is rich in community resources and will support this program with a wealth of wrap-around services. Several services that are evidence-based or research-based, have been identified to be used in conjunction with the PAT+ program. The following tools or services were chosen to meet the specific needs of prenatal women, children age 0-3 and their families in Pinellas.

Developmental screening: The Ages & Stages Questionnaire 3 (ASQ 3) will be used for developmental screening to identify developmental delays in project children and the ASQ Social-Emotional (SE) to identify social/emotional concerns. The ASQ 3/SE will be administered at regular intervals to assess areas of communication, gross motor skills, fine motor skills, problem solving, personal-social skills, and overall development across time. The ASQ/SE will be administered at least annually. The Brookes Ages and Stages database, operated by the

Early Learning Coalition (ELC) will be utilized as a common site to enter developmental screening results. To avoid duplication, completed ASQ and ASQ-SE results for a child attending a school readiness program will be sent via FAX to the ELC for data input. The Parent or legal guardian must sign a consent to release the developmental screening results prior to sending the results. Participants with abnormal screenings will be referred for further developmental assessments to the community provider, West Central Early Steps.

Motivational Interviewing (MI), a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients explore and resolve ambivalence, will be used when providing prevention services and home visits. MI is included in SAMHSA's National Registry of Evidence-Based Practices and Programs and has been applied to a wide range of problem behaviors related to alcohol and substance misuse as well as health promotion, medical treatment adherence, and mental health issues.

Mental Health Services: The Central Florida Behavioral Health Network (CFBHN) is a community services network that helps to bridge the gap in the system of care by completing in-home assessments and referrals to existing mental health programs. Individuals who present signs or symptoms of possible mental health issues will be referred for mental health consultation with HSC contracted providers or the CFBHN. The Healthy Start Coalition contracts with Suncoast Center and Directions to provide mental health counseling in the home setting. These services will be offered as an "in kind' service to PAT+ families. Project staff will use the Beck Depression Inventory Scale, the Perceived Stress Scale, and the Edinburgh Postnatal Depression Scale as the mental health-screening tools to identify parents who need mental health services.

Substance Abuse Prevention and Treatment: Substance abuse treatment options in the area include day treatment groups and residential treatment. The primary providers are Operation PAR and WestCare Gulf Coast-Florida, Inc. Substance misusing pregnant women referred to those providers from the PAT+ program will be given priority for treatment if Medicaid funding is available. WestCare, a licensed provider of substance abuse prevention and treatment services, will offer a certified addiction professional to provide substance abuse training and supervision for PAT+ staff on drug misuse issues. There are also many community-based Alcoholics Anonymous/Narcotics Anonymous (AA/NA) and 12-step meetings that family members may attend, as well as numerous specialty groups addressing many related issues.

Adult Literacy Services: Parents in need of a high school diploma will be referred to Pinellas County Schools (PCS). PCS offers adult education classes at more than 40 facilities throughout the county. Classes are offered year-round with evening hours; virtual classes are also available. St. Petersburg College and Pinellas Technical Education Center also offer comparable services. Support services available to PAT+ families who enroll in the adult education programs include career counseling, tutoring, academic advising, GED exam scholarships, child care assistance, financial aid counseling, college readiness skills assistance, work readiness skills assistance, transportation, social services, and job placement.

WORKING WITH THE NATIONAL MODEL DEVELOPER

The Parents as Teachers National Center, Inc. is a not-for profit organization that provides PAT training and technical assistance, certification for PAT parent educators, curriculum and materials development, research and evaluation coordination and international conferences.

All service providers who will deliver PAT services, as well as supervisors, will attend the Foundational and Model Implementation Trainings. Furthermore, service providers will have access to competency-based professional development and training and will recertify with the national office annually. Within the first year, services providers will be required to have 20 hours of professional development. In year two, 15 hours of professional development will be required. Thereafter, 10 hours of professional development are required annually.

The PAT State Office supports Florida PAT Programs by coordinating trainings, providing technical support, publishing newsletters, advocating for the program, and collaborating closely with other home visiting programs. The Healthy Start Coalition in Pinellas County will avail themselves to these entities for assistance in implementing the model successfully.

MODEL FIDELITY AND QUALITY ASSURANCE

The PAT + model will be implemented with quality and fidelity and maintained through the length of grant. In Pinellas county, PAT has been implemented and maintained with fidelity in the Healthy Start program for one year and in the Even Start program for five years. Program fidelity will be measured using PAT data collection tools and required reports will be submitted to the PAT National Office. The PAT+ supervisor is well versed in the PAT standards and requirements and will ensure that they are maintained throughout the program. Regular communication with the National Office and the state coordinator for PAT will assist in maintaining quality and fidelity.

The program will conduct quarterly reviews of its process and outcome data for both infrastructure and client level data. Routine analysis will include demographics, methods of recruitment, attendance, attrition, planned and unplanned adaptations, cultural problems/issues, indicators of unmet needs, client-level changes at discharge and 6-month follow-up as they relate to the goals and objectives. In addition, the project will conduct annual analyses to ensure the project is attaining program goals and objectives and adherence to implementation and action plans. Reviews of client records will be performed quarterly by the HSC and the PAT+ supervisor. Results of quality monitoring of key performance indicators and corrective action plans, if necessary, will be reviewed by the QI committee of the Healthy Start Coalition.

ANTICIPATED CHALLENGES

The families served by home based intervention services are by definition of the program, at risk, and therefore, challenging to work with. Due to their under or un-employment status, substance abuse or domestic violence issues, the families often do not remain in the program for the intended or needed length of time to reap the benefits of the curricula and services. In many instances, the families do not regularly attend the home visits or group meetings offered due to lack of transportation or other more pressing demands. An anticipated challenge will be to keep clients in the PAT+ program for at least 18 months due to the relapse factor often seen

in drug-using clients. The court system may be a helpful incentive to remain in the voluntary evidence-based home visiting program as an alternative to jail.

Specialized training will be built into the pre-service training to support the PAT+ team. Training and team meetings will also occur on a regular basis to monitor strengths and concerns. PAT+ staff will be invited to participate in training sessions with Healthy Start and other community agencies. A certified addiction professional from Westcare will provide on-going training and supervision of the PAT+ team related to substance misuse and drug treatment issues. Operation Par has also agreed to be a resource.

At this time there are no anticipated technical assistance needs. Any concerns with the program curriculum will be addressed through the Parents as Teachers State Office located nearby at the University of South Florida, or with the National Program.

ESCAMBIA COUNTY

Escambia County has selected Healthy Families America (HFA) as the evidence-based home visiting model that best meets the needs of the community. The decision to expand the existing Healthy Families Florida (HFF) program, an HFA accredited program, was based on the number of families that are at high risk for child abuse and neglect, the ability of the HFA model to impact the benchmark areas addressed in the legislation and the demonstrated success and infrastructure of the existing program. At this time, the number of families in need of Healthy Families services exceeds the capacity of the current program and it is essential that Escambia County add another team of home visitors to expand the service area. Expanding this program will serve the entire county except for the three high-risk zip codes already covered, thereby filling the existing service gap.

WORKING WITH THE NATIONAL MODEL DEVELOPER

As described earlier, the Florida Healthy Families program is part of a multi-site system, and the HFF Central Office, rather than the national model developer will provide training through the HFF Training Institute (Institute). The Institute provides the intensive training required for all staff, allowing for a cost effective process in training new hires and meeting all of the training requirements of the HFA model and the HFF Central Office. Requirements include pre-service training on core competencies specific to each of the staff roles and training on the Healthy Families Parenting Inventory; interactive, hands-on training using the primary home visiting curriculum, Growing Great Kids, within three months of hire; and domestic violence and child abuse and neglect within six months of hire. Staff will attend ongoing training workshops through the Institute on topics such as mental health, substance abuse, positive discipline strategies, respecting boundaries, recognizing red flags, motivational interviewing, and strategies for effectively engaging families. In addition to attending face-to-face trainings, staff are required to complete Web-based trainings on a variety of topics and demonstrate knowledge through competency-based tests. The majority of training is provided within the first year, but staff are required to receive ongoing training after the first year. Supervisors are also required to work with the staff to determine additional professional development activities for each person.

MODEL FIDELITY AND QUALITY ASSURANCE

Healthy Families Escambia has been accredited by HFA, as it has been demonstrated that model fidelity has been met and quality services are provided in affiliate sites. In addition to accreditation, HFF monitors performance at least quarterly and conducts annual quality assurance visits to ensure adherence to the model. One of the most common challenges to maintaining the quality and fidelity is completing home visits. Without home visits, it is difficult to accomplish any of the stated goals. Some families are more challenging in this area than others. For those families whose schedules are more unpredictable and are sometimes not home for their appointments, it is important to schedule visits more frequently, confirm the times of the home visits, conduct drop-by visits to see how the family is doing, and arrange for another home visitor to see the family if the primary home visitor is unavailable. Program staff is committed to ensuring that the services are engaging and meeting the families' needs.

The Healthy Families model demands fidelity. Since Family Support Workers are paraprofessionals, the Healthy Families program requires extensive training in this field as well as weekly, one hour individual supervision for all staff. The supervisor is also required to provide feedback from field visits with the workers. The Healthy Families program team holds a staff meeting once a week to provide support and feedback for the home visitors.

The Families Count Healthy Families program is accredited by both Healthy Families America and Commission on Accreditation of Rehabilitation Facilities. In addition to the critical role of supervision, the HFF Central Office conducts annual quality assurance (QA) site visits. The purpose of the site visit is to monitor contract compliance and adherence to the HFA model and HFF Policies and Procedures. During the site visit, the Central Office staff will: 1) conduct a review of participant files and supervision notes; 2) observe and or interview the family assessment worker to determine adherence to the requirements related to screening and assessment; 3) observe and interview the home visitors and supervisors. Additionally a review of the project policies and procedures, program materials, advisory board minutes, interagency agreements, personnel, and training documentation is conducted. Most importantly, interviews with participants on their experience and overall satisfaction with the program are held. The HFF Central Office will also provide technical assistance, as needed, on meeting the outcomes required.

On site, the supervisor performs quality assurance checks to ensure that screens are uniformly scored and that eligibility assessments are conducted systematically to ensure all risk factors are explored with the family prior to enrollment. Once a family is enrolled, the supervisor and home visitor work together to develop a plan for addressing all of the risk factors identified at the time of assessment and during services. Staff may become aware of additional risk factors through observation, discussions with the family, or through the administration of various tools.

ANTICIPATED CHALLENGES

As with implementing any new program or expanding/enhancing an existing one, there are anticipated challenges. These challenges may include recruitment of staff and families, and retaining families. If plans for hiring and recruiting families are delayed, the timeline for implementation and achieving success on the benchmarks within the time frame may change.

Knowing these challenges ahead of time allows opportunities to implement strategies to minimize the impact. Recruitment for positions will be conducted as early as possible. Having years of experience with this model, policies and processes are in place to select the best people for the positions.

Additional challenges include meeting program outcomes and providing quality training for paraprofessional staff. Families Count has improved program outcomes in the last few years and incorporated the model into our other service programs for company-wide fidelity. Families Count also incorporates required program outcomes into the job description so the employee's bi-annual performance appraisal is based on their success in meeting Healthy Families standards.

What is unpredictable is the number of families that move away, which could affect the number of families served over the 12 month period.

The HFF Central Office will provide technical assistance on maintaining quality while implementing the enhancement to the model and expanding services in accordance with the grant requirements. The budget includes two on-site technical assistance visits to assist in meeting the expectations and will also provide on-going technical assistance through e-mails, conference calls, and Webinars. The only technical assistance anticipated from the Department of Health (DOH) would be related to the requirements for data collection and reporting, when those are specified. Families Count will work with DOH and the evaluation team in conjunction with the HFF Central Office to meet these requirements.

DUVAL COUNTY

Nurse Family Partnership (NFP) offers an evidence-based model that addresses a gap in Jacksonville's current continuum of home visiting services by using specially trained nurses to provide intensive, long-term education and support to first-time mothers living in high-risk communities. NFP is intended to equip parents with the knowledge, skills and tools they need to raise children who are healthy, safe and ready to succeed in school. NFP was selected for implementation for two primary reasons:

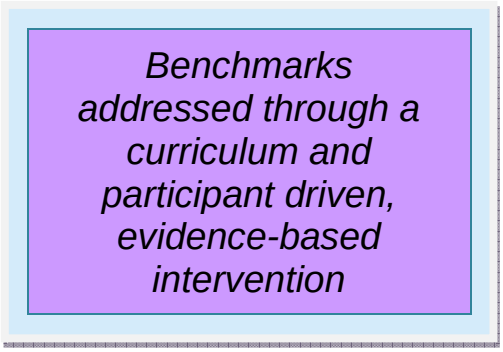
1. In addition to MIECHV goals, NFP has a demonstrable impact on repeat teen births and short inter-pregnancy intervals — priority problems in Duval County identified by the Coalition in its *2009-2014 Healthy Start Service Delivery Plan*.

2. The need for NFP was specifically identified in the strategic plan developed by the New Town Success Zone (NTSZ) Early Childhood Subcommittee in the Fall of 2010. NTSZ has focused significant resources and attention on the development of a continuum of family support services from prenatal to pre-college in a neighborhood in Health Zone 1 that will contribute to the successful implementation and sustainability of the NFP program.

While Duval County has achieved notable improvements in its overall infant mortality rate, poor standing on several key risk factors — including repeat teen births and short inter-pregnancy intervals — threaten continued progress. The current system of home visiting services has

been unsuccessful in addressing these risk factors because it lacks an appropriately intensive, focused intervention like the one offered by NFP.

NFP complements and enhances existing home visiting models available to support vulnerable families in Duval County. It is more intensive and structured than the state Healthy Start program, even for Level III (most at-risk) families. NFP is most effective with the highest-risk families — young first-time mothers living in poverty — who are socially isolated and hard-to-serve. No home visiting program available in Duval County has the capacity to serve this vulnerable group. NFP also utilizes nurses as home visitors expanding the capacity of the current home visiting continuum which includes two paraprofessional evidence-based models (Healthy Families America and Early Head Start). Priority for participation in the proposed NFP will be given to low-income, first-time mothers at highest risk (<21 years old, history of substance abuse or tobacco use, <high school education), as well as eligible military families at the Naval Hospital Jacksonville. More than 700 military families living in Duval County give birth at this hospital annually. Families with these risks are identified as high priority in both the state MIECHV plan, and the Coalition's 2009-2014 Healthy Start Service Delivery Plan.



According to published scientific literature and federal government guidance, NFP addresses all of the six MIECHV benchmarks: maternal & child health, child development & school readiness, family economic self-sufficiency, positive parenting practices, reductions in child maltreatment and reduction in juvenile delinquency, family violence and crime.

NFP positively impacts these benchmarks through a curriculum and participant-driven, evidence-based intervention. This curriculum focuses on three sets of visit-to-visit guidelines: pregnancy, infancy, and toddler. These guidelines cover a range of topics supplemented with educational material. Assessment, goal setting and behavior change are integrated into each visit. Participants focus on short and long-term goals in their lives to achieve the program goals of healthy pregnancy outcome, healthy child growth and development and life-course self-sufficiency.

Model Fidelity and Quality Assurance

The NFP program in Duval County will adhere to all policies, protocols and procedures established by the National Office in terms of required assessments, caseloads, frequency, and content of visits; data collection and documentation, quality assurance, staffing ratios and supervision, and program monitoring. It will be grounded in the theoretical framework that underpins NFP, emphasizing self-efficacy, human ecology, and attachment theories.

Anticipated Challenges

The Coalition will implement the NFP program without adaptation. The most significant implementation challenge faced by the proposed project is the ability of the health department to hire additional staff through the state system. This challenge will be addressed in two ways: 1)

by giving hiring priority to existing Healthy Start and county health department staff who are qualified and committed to meeting NFP goals and standards, and 2) by utilizing a special classification for the nursing positions created by the Palm Beach County Health Department when it implemented the NFP program two years ago. This classification allows the agency more flexibility in salary levels and hiring procedures.

SUMMARY OF SELECTION OF MODELS

The resources, infrastructure, and community needs are different in each of the selected high-risk areas. Commitment to serving their vulnerable residents was evident in the description of the collaboration and coordination efforts with their community agencies.

In the rural counties, Healthy Start is often the primary source of screening, assessment, and referral services for maternal and child health care, playing an integral part in service delivery. By incorporating the evidence-based PAT model into the current Healthy Start system for all 12 counties as proposed by the Healthy Start of North Central Florida, an economy of scale and great cost savings is realized in this large geographic area.

For Duval County, which is has a plethora of services available to women and children, the NFP model complements the existing clinic-based services offered through the various agencies and hospitals. Since teen pregnancy is an identified concern in the Duval county area, NFP is an ideal solution to address the interconception care and ensure healthier outcomes for the women and infants.

Substance abuse is a significant problem in Pinellas County based on the statistics reported. The use of drugs and alcohol during pregnancy create dire consequences for the mother and infant and results in a great cost to themselves and the community. The PAT Plus model is well suited to serve this difficult population and serves an identified gap in delivery of services.

Healthy Families Florida is the largest home visiting program in Florida and Families Count in Escambia County is experienced with the model and will be able to expand the services to reach the entire county to serve all eligible families with the education, resources, and support to improve the lives of children in their area.

The Departments will work with these communities to ensure that the goals and objectives of the statewide program are met at the local and state infrastructure levels. Additionally, to ensure model fidelity, collaboration with the state coordinators and national developers as appropriate, will occur as outlined in the next sections. Letters of Approval from all seven national evidence-based model programs have been provided to the DOH co-lead and are included in Appendix 7.

SECTION 4: IMPLEMENTATION PLAN FOR PROPOSED STATE HOME VISITING PROGRAM

As depicted in the logic model for the Florida MIECHV Program, there are three distinct program components: state infrastructure, local infrastructure, and the local home visiting services themselves. All three of these components will be integrated to ensure that the initial and continual implementation of the programs, delivery of services, and evaluation of the participant outcomes will occur at each of these program levels. This section describes the policy and standard development at each of these programmatic component levels.

STATE'S APPROACH TO DEVELOPMENT OF POLICY AND STANDARDS FOR THE STATE HOME VISITING PROGRAM

As described in Section 1, Florida engaged the communities through a Request for Application process to determine the communities and appropriate models for the home visiting program. During the development of this updated state plan, the workgroup determined that Florida is well positioned to add the MIECHV Program into the array of services currently provided to families. Section 6 describes the plethora of agencies and councils committed to supporting and enhancing the health and education of young children in Florida. The Departments will draw upon these peripheral agencies to assist in the integration of the home visiting programs at the state and local levels.

The Departments will also utilize the expertise of the Home Visiting Coalition, a statewide organization whose members represent every program in the state that provides a home visiting component as part of its system of care, to develop policy and set standards for the state, as well as identify ways to support the new local programs. The Departments will also form a new MIECHV Task Force comprised of all the stakeholders related to home visiting and the early childhood system of care to assist in this process. The roles of the Task Force and the Coalition are described in greater detail in Section 6.

Implementing three models in five communities for the first year will afford the Departments the opportunity to respond to any obstacles or challenges and make appropriate changes before additional programs are included in the next phase of implementation.

The MIECHV Program Team

Although both the DCF and the DOH are designated as state co-leads on this program, the Department of Health will be the primary administrator of the funds. Programmatically, however, the two agencies, along with the university evaluator, will blend together to implement the Program and function as one team to ensure administrative, evaluative, and programmatic coordination and success.

The Program Team will include two state co-leaders, six professionals, and the evaluation team members (Figure 4.1). Peripherally, the Team will have access to the Director of the DCF Central Office of Family and Community Services, Director of the DOH Central Office Family

Health Services and the state's Title V Director, the DOH lead epidemiologist and senior data analysts from both departments.

Program Administrator (DOH and DCF)

One of these two full-time positions will be located at DOH Central Office, Bureau of Family and Community Health and the other at DCF Central Office. Responsibilities include supervision of the programmatic development, project and contract management, and overall daily management of the MIECHV Program. The Program Administrators have responsibility for management of program staff to ensure that the program is implemented as outlined by the grant guidance, this plan, and by plans submitted as part of each community's proposal.

Community Health Nursing Consultant: Program Staff (DOH)

This full-time position will be located at the DOH Central Office. Responsibilities include assisting the Program Administrator with the development and implementation of the MIECHV Program, acting as liaison to DCF, conducting programmatic development, assisting with core competency training, research, and training as well as project and contract management.

Medical Health Care Program Analysts: Program Staff (DOH and DCF)

One of these two full-time positions will be located at the DOH Central Office; the other will be housed at the DCF Office of Family and Community Services. Responsibilities will include assisting the Program Administrators with the development and implementation of the MIECHV Program grant and contract management. An analyst was hired in January 2011 and comes to the program with a Masters in Public Health and experience in evaluating social services programs and implementing new outreach strategies to high-risk communities. A second analyst is expected to be hired in June, 2011.

Staff Assistant: Program Staff (DOH)

A staff assistant was hired in April 2011 and is located at the DOH Central Office. Responsibilities include assisting the Program Administrator, analysts, and nurse with the administrative functions as they relate to the MIECHV Program.

State agency staff position descriptions and resumes can be found in Appendix 8.

Evaluation Team

Through an anticipated contract with the DOH, the evaluation team will lead the evaluation efforts. Primary staff include a project director who will supervise project staff and activities and is responsible for overall administration, including budget and contract requirements.

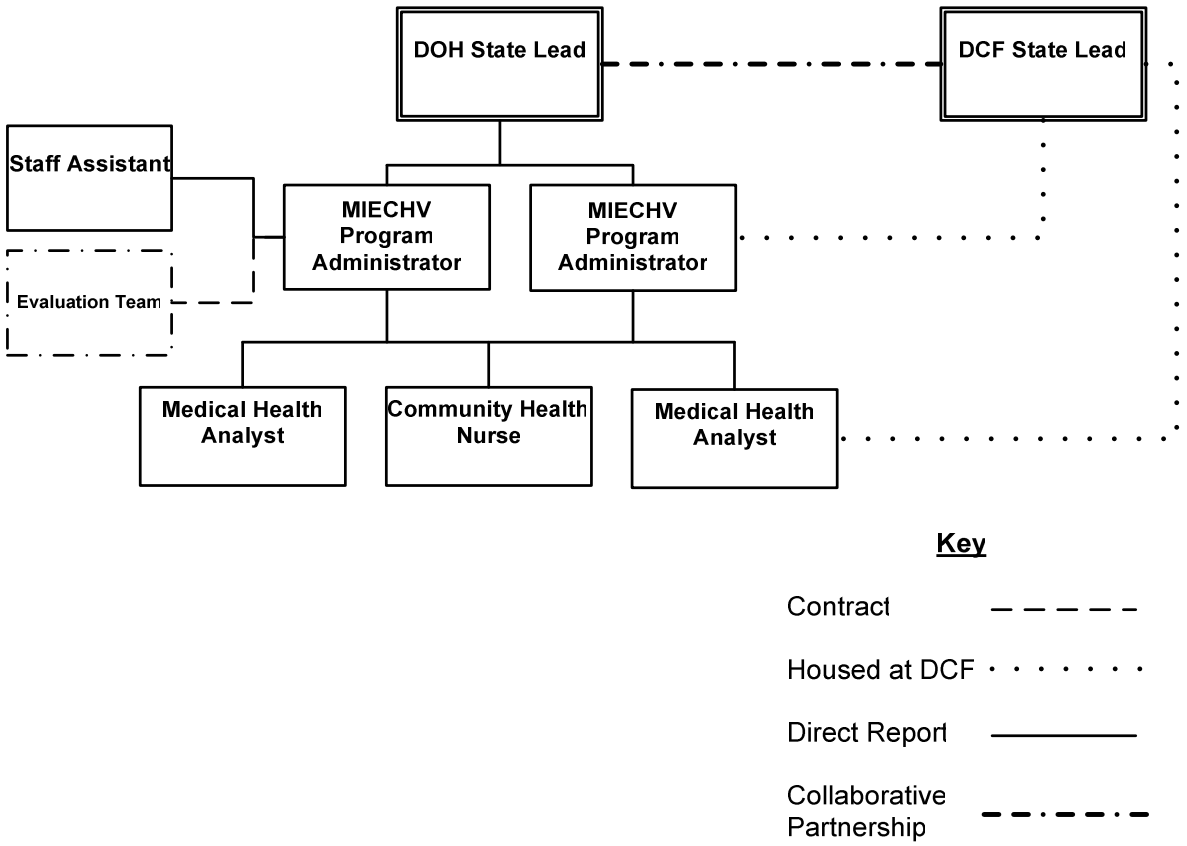
The principal investigator will be responsible for the design and development of the evaluation components (processes and outcomes), providing data for Continuous Quality Improvement (CQI) data, as well as organizing and overseeing the ongoing evaluation of the programs at the state and local levels.

Additionally, the evaluation team will include a data administrator, a national expert in the evaluation of home visiting programs, and a consultant with extensive experience providing

technical assistance to communities in the development of systems of care. Figure 4.1 depicts the Program Team.

Figure 4.1

Maternal, Infant, Early Childhood Child Home Visiting Team



All six staff members of the Program Team will be certified as contract managers. Primarily, the two analysts and the nurse will manage the contracts with the local organizations implementing the home visiting programs. Contracts with providers will be developed based on the home visiting models to be implemented and the population to be served.

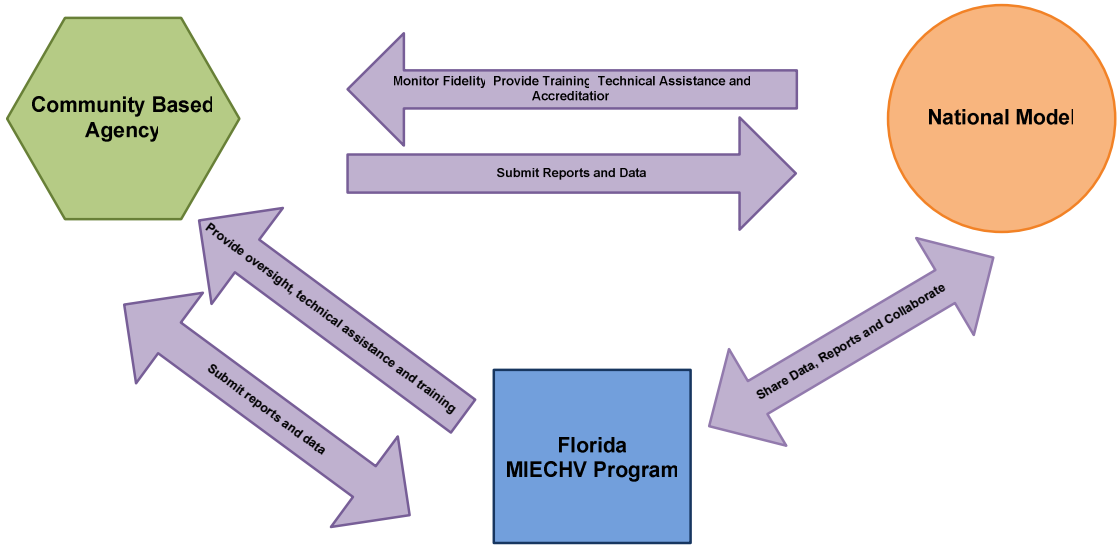
Oversight to Address Model Fidelity, Quality Assurance and Program Standards

To avoid duplication and overlap of services, the national office, or other designated oversight entity of the selected home visiting programs, will provide training and technical assistance to the awarded programs in Florida to meet the requirements of the model. Monitoring each location's fidelity to the model will also continue to be conducted by the appropriate national home visiting entity. The Departments will work collaboratively with the national program offices to share information and ensure seamless coordination. Relationships have already been established with the PAT State Coordinator and the HFF Central Office Director.

Figure 4.2 below illustrates the collaborative relationships between the national model, Florida's MIECHV Program and the community-based agencies.

Figure 4.2

National, State, and Local Collaboration Plan



The Program Team will be responsible for the monitoring of contracts with the home visiting providers to ensure that the necessary policies and practices are in place to ensure a cohesive and effective holistic system of care. Monitoring activities will include, but not be limited to, review of quarterly expenditure reports and performance indicators, quarterly conference calls, and annual site visits with provider agencies. Monitoring activities and annual site visits will be shared with the evaluation team. Department staff will focus on adherence to the terms of the local providers' contracts while the evaluation team will conduct interviews and or focus groups to verify that existing processes and progress are consistent with what is documented in quarterly reports. In addition, the evaluation team will identify information about local obstacles to effective program implementation and about the level of engagement of the local system of care that can be used as a basis for future technical assistance.

Contracts with providers will require that services are provided on a voluntary basis to high-risk families and that families receive individualized assessments to determine service needs. In collaboration with the home visiting model developers, the state team will make certain that providers have the appropriate infrastructure in place to implement the model with fidelity. The infrastructure will need to include a system to ensure staff competence and a method for collecting and managing the required data elements. The Program Team will evaluate whether program models are effectively addressing implementation challenges such as staff retention, participant enrollment, and client retention rates.

Monitoring activities will also assess the adequacy of training and supervision that home visitors receive. The Program will require that protocols are in place to ensure home visitors are provided regular supervision and in-service training. Home visitors will not only need educational experiences to learn the necessary skills but will also need on-going coaching and emotional support. Home visitors also need opportunities for peer support and networking. If the program is using paraprofessional staff, programs will be expected to provide access to a mental health consultant to assist home visitors to work effectively with families who are experiencing substance use disorders, mental health disorders, or domestic violence.

The Program Team will share findings and recommendations with the local agencies, as well as the appropriate model expert so that a unified approach to assisting the communities is explored and engaged.

Quality Assurance

In collaboration with the national model developers, the Program Team will develop a web-based case management system with the dual purpose of promoting effective case management by home visitors and collecting data on participant characteristics, participant needs, engagement rates, services, and service outcomes. A reporting tool will be created for submission of quarterly data to the Department of Health, as well as, to the national model developers.

Programs will be assessed on their use of data for ongoing quality assurance efforts. A Continuous Quality Improvement process will be utilized to systematically review overall program operations and client outcomes. Home visiting providers need to have a system for evaluating program implementation so that services can be improved and problems can be identified and addressed. Because many home visiting programs struggle to enroll, involve, and retain families, it will be important to assess the program's success at engaging families in the program.

Home visiting programs will also be evaluated on the level of collaboration and sharing of information with other service providers. The Program Team will review the local relationships supporting the program and the involvement of the provider with local planning groups such as the Child Abuse Prevention and Permanency (CAPP) local planning team, the DCF community-based care organization, or the Healthy Start Coalition. The MIECHV Program must be part of a broader system of support for parents of young children with linkages established to health care, child care, and education. The Program Team will ensure that mechanisms are in place for a coordinated system of outreach, screening, and referral to the most appropriate provider agency.

Monitoring activities will assess the level of family involvement in the home visiting program. Families are expected to have a voice at the service level and will be given opportunities to provide input regarding their strengths, service needs, and to become partners in service delivery planning. They will also be involved at the management level to assist with quality improvement efforts. It is expected that families will have opportunities to influence program development and implementation decisions to make certain that services are culturally appropriate and accessible. This will be achieved by their participation in the local Advisory Councils as well as attending the statewide Advisory Council meetings, which will be supported

by the local HV program budget. Quarterly reports prepared by the evaluation team for each implementing community will be used as a basis for provision of both customized and universal technical assistance. These reports will provide information on:

- Staffing
- Case loads
- Case planning
- Provision of services to meet identified needs
- Utilization of referrals
- Attrition rates
- Utilization of community task forces
- Utilization of training opportunities

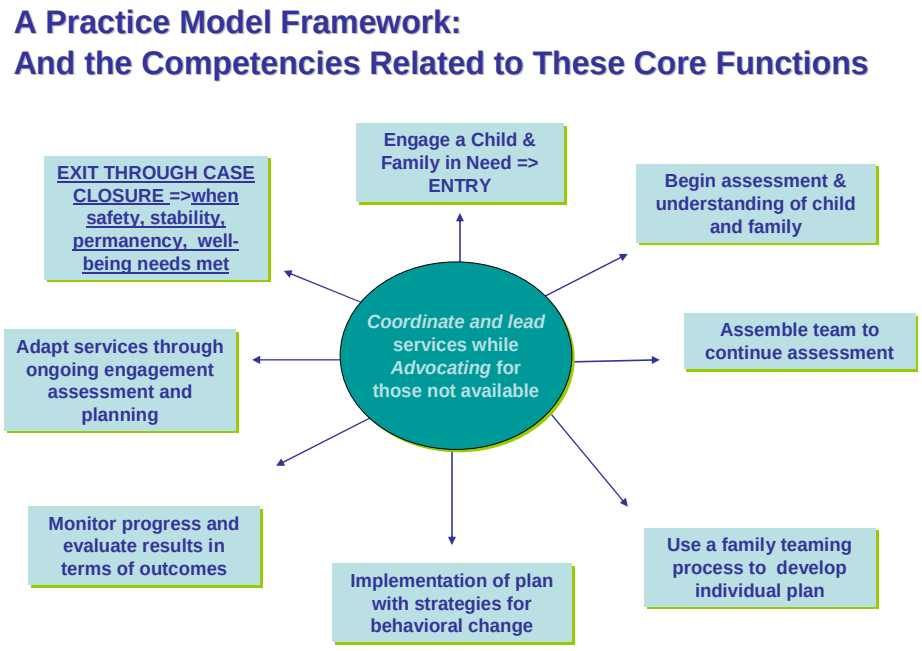
Based on the results of quarterly reports derived from local program data, the Program Team will provide technical assistance focusing on improving the quality of programs and strengthening the continuum of services for young children and their families. In collaboration with the national model developers and the Florida Home Visiting Coalition, the Program Team will facilitate community-wide or regional staff training and in-service programs to support the development of core competencies for all home visitors. The Program Team will establish a listserv to include web-based trainings and opportunities for peer networking and support.

Additional Support

The DCF has adopted a Family Centered framework for its child protection system. The Family Centered Practice requires an understanding of the family and each member within the full context of their experience. The DCF is also aligning the framework with the protective factors. The five protective factors are research-based conditions in families (and communities) that, when present, increase the health and well being of children and families. The CBCAP has been providing technical assistance on assessing families' strengths within family-centered practice. The DCF recognizes a strength-based assessment as critical to understanding the full context of the family and provides a basis to measure improvement over time. In keeping with the State's Five Year Child Abuse Prevention and Permanency Plan home visitors will receive training on engaging and building trusting relationships with families, developing capable teams around the child and family, using the team to assess strengths and needs, and developing individualized plans with strong family involvement that support and enhance the Five Protective Factors.

The Family Centered Practice model illustrating the family team conference process is illustrated in the figure below.

Figure 4.3



TECHNICAL ASSISTANCE AND SUPPORT FOR THE MODELS

Florida has experience with all three of the models that will be initially funded in this Program. Healthy Families Florida and PAT each have a statewide coordinator available for the local programs. These coordinators served on the Steering Committee and have proven to be valuable resources to the communities as well as the Departments. The Program Team will work closely with the coordinators to ensure implementation of the models meets both the national requirements as well as the standards determined by the state Program. The regional liaison for Nurse Family Partnership has met with the Program Team and has committed to collaborating with the Program Team to implement a second NFP model in Florida.

The Program Team is committed to provide guidance to the local communities to improve coordination efforts and provide recommendations, strategies and technical assistance to close or remove any gaps in service delivery. Section 8 details the potential training opportunities that the Program will explore and provide to the communities.

Budget and Timeline

The FY 2010 – 2012 budget for Florida's MIECHV Program includes funding for the implementation, evaluation, and model implementation in the five identified communities. See Appendix 8 for the full budget. Florida at this time has not been affected by the Maintenance of Effort requirement. The Program Team and administration will continue to monitor this throughout the life of the grant. A rebuttal will be sent to HRSA further detailing the current situation of funding home visiting programs since March 23, 2010 and in future state budget years.

At this point, a timeline has been developed through July 2012 as funding beyond FFY 11-12 is uncertain. It is expected that a second group of high-risk communities will be selected and begin implementation by July 2012. This one year timeline can also be found in Appendix 8.

Anticipated Challenges

The greatest challenge for the Florida MIECHV Program will be establishing a data collection system and methodology to evaluate the efforts of the initial five communities as well as subsequent communities in future years. The Departments and the evaluation team will need to work with each of the three models at the national and local levels to develop a system to collect and evaluate the data that does not greatly interfere with their own processes for collecting client data. The Program Team recognizes that the implementation and evaluation of multiple evidence-based programs is not a single event, but rather a process that will require extensive planning, cooperation, and diligence.

Communities' Approach to Development of Policy and Standards for the State Home Visiting Program

This section describes the communities' plans for incorporating the home visiting model into their existing maternal and child system of care as outlined in the State's logic model.

Putnam, Bradford, and Alachua Counties

Engaging Participants

The entry point for the families that are identified as needing PAT services is through the state's universal screening process or through self and community referrals into the Healthy Start Program. Healthy Start relies on community partners such as Healthy Families, Childhood Development Services, Early Learning Coalitions, Department of Children and Families, Early Steps, Early Head Start, and Head Start, to reach families not identified by the universal screening process. In addition to already identified partners, HSNCF will actively work towards building partnerships to identify more families in need of services through systematic community referrals.

The HSNCF's Community Liaison will conduct outreach to promote awareness of the program by participating in community events such as March of Dimes walks, health fairs, and the World's Greatest Baby Showers. Additionally, Healthy Start advertises its free services through a variety of mass media and local grass-roots efforts to increase name recognition in the community as well as to promote self referrals.

Retaining Families

Quality service delivery by highly-skilled parent educators, as well as the relationship built between the parent educator and the family, is ultimately what impacts program participant retention, duration, and satisfaction. The HSNCF will ensure quality services through the comprehensive QA/QI processes described earlier and by recruiting, hiring, and retaining well-trained and competent service providers. In addition to quality service provision and relationship building, direct service staff can encourage retention through frequent and consistent

engagement of the families, using strategies such as visit reminders through a variety of communication methods (letters, emails, social media, text messages) and the provision of incentives and transportation to group meetings.

Recruiting, Hiring, and Retaining Staff

Additional staff will be hired and trained along with current staff housed at Healthy Start to implement the new program. With the additional Healthy Start staff trained in the PAT model, it is estimated that nearly 450 families will be served in the three county area. The HSNCF currently contracts with the Family Medical and Dental Center, Bradford and Alachua County Health Departments for Healthy Start service delivery. Each service site is responsible for recruiting and hiring service providers. The educational requirements for Healthy Start service providers closely match requirements specified by PAT.

In addition to the home visitors, the HSNCF will hire a PAT program director who will oversee all three counties. The director will supervise the supervisors in each county and oversee the operation of the two programs. The supervisors will communicate, motivate, train, and respond to employees who are trained in the PAT program by planning and directing their work as it relates to the PAT model.

Services will be provided by highly qualified providers with direct ties to the community and who recognize the cultural differences unique to their communities. Putnam and Alachua Counties have significant migrant worker populations and have hired or will hire Spanish speaking care coordinators. Bradford County is primarily a rural, white population requiring no additional linguistic services.

Assurances

The goals and purpose of the PAT program align with the expected outcomes described in Section 511: MIECHV Programs of the Patient Protection and Affordable Care Act of 2010. The expected outcomes that will be addressed are: improved maternal and prenatal health, infant health, and child health and development; improved parenting practices related to child development outcomes; and improved coordination of referrals and access to community resources and support.

Ongoing assessment of participant families is at the foundation of the Healthy Start and PAT programs. All families will be contacted and assessed for a wide array of social and health indicators as well as current strengths and assets. Once a client is assessed, each family will work with the home visitor to develop a comprehensive, individualized plan of care based on their identified risks and needs. This plan of care is reviewed and revised at each client contact to ensure that every support and service needed is being provided. Program participation is completely voluntary which aligns with the state's Healthy Start legislation. A client may refuse any or all services at any point.

Any pregnant or postpartum woman or child up to age three will be eligible for the PAT program. Clients to be served are pregnant women, children up to age three and their families. Populations typically served include, but are not limited to, low income families, first-time and young moms, families that have a history of substance use, and tobacco users. Families identified as having safety issues, a history of abuse, history of substance use, or with a tobacco

user in the home will be triaged as urgent need and a greater effort will be made to reach out to these families and get them into services. Additionally, many services provided are reimbursable through Medicaid, providing an additional incentive for providers to reach out to low-income populations.

Obtaining or Modifying the Data System for Continuous Quality Improvement

The HSNCF is committed to the adoption of an evidence-based home visiting curriculum and to work with the DOH and evaluation team to establish a data collection process for the required data. While PAT has data collection requirements in place, strategies for collecting and reporting the required data to meet the federal requirements will depend upon the variables to be measured and the decisions made by the program evaluator. Through a collaborative effort with community partners and consent from program participants, the benchmark data and respective constructs will be identified and collected in a data system. The DOH and evaluation team will develop the data collection and management methodology in consultation with the HSNCF, PAT State Office, and the National PAT Office. A sustained effort will be necessary to provide on-going staff training and supervision of data collection.

Estimated Timeline

It is expected that the HSNCF will be able to attain program capacity by March 2012. The chart below details the activities required to achieve implementation in Putnam, Bradford, and Alachua Counties.

Table 4.1

Action Step	Start Date	End Date
1. Notify subcontractors of successful application and impending award	May 16, 2011	May 20, 2011
2. Include the provision of Parents and Teachers services in the 2011-2012 contracts with Putnam County, Bradford County, and Alachua Healthy Start service providers	May 20, 2011	June 30, 2011
3. Execute MIECHV contract with DOH	July 1, 2011	July 1, 2011
4. Execute contracts with Putnam County, Bradford County, and Alachua Healthy Start service providers	July 1, 2011	July 20, 2011
5. Recruit and hire PAT Program Director	July 1, 2011	July 30, 2011
6. Ensure contracted service providers have hired additional staff	July 1, 2011	August 15, 2011
7. Coordinate and provide PAT training for supervisors and direct service staff who will provide PAT services	August 15, 2011	September 30, 2011

8. Coordinate and provide Healthy Start training on HSSG and coding to new staff	August 15, 2011	September 30, 2011
9. Service providers will begin providing PAT services to clients	October 1, 2011	On-going
10. Coordinate monthly meetings with Healthy Start staff	October 1, 2011	On-going
11. Collect on a monthly basis the number of PAT services provided by Healthy Start staff	October 1, 2011	On-going
12. Collect on a monthly basis the caseload for each service provider	October 1, 2011	On-going
13. Collect on a quarterly basis client satisfaction surveys and analyze data	October 1, 2011	On-going
14. First meeting of the initial home visiting advisory groups to conduct strategic plan	October 1, 2011	October 31, 2011
15. Conduct QA/QI record reviews on service providers on a semi-annual basis	October 1, 2011	On-going
16. Facilitate quarterly meetings of the home visiting advisory groups	November 1, 2011	On-going
17. Service providers will be at maximum caseload	March 1, 2012	On-going
18. Develop an evaluation of neighboring PAT projects	July 1, 2012	December 31, 2012
19. Conduct the PAT evaluation	January 1, 2013	March 31, 2013
20. Complete the evaluation and analyze data	April 1, 2013	June 30, 2013
21. Provide local evaluation results to the local home visiting advisory groups, partnering PAT projects, the PAT state coordinator and the DOH.	July 1, 2013	July 15, 2013

PINELLAS COUNTY

ENGAGING PARTICIPANTS

For 18 years, the Healthy Start Coalition has actively collaborated with organizations in the community to meet the needs of families. During this application process, multiple organizations were engaged in planning how to address the existing service gaps and needs of this target population in Pinellas. In addition to the primary partners previously listed, the following organizations were identified as having resources that might meet the needs of the families at risk: Social workers in birth hospitals, Pinellas Drug Court counselors, WestCare counselors staff, DCF, Healthy Start risk screening and medical providers will provide outreach/recruitment functions. Social workers in the birth hospitals interview women and will refer those who may benefit from the PAT+ program. Women who agree to participate will be contacted within five days by a PAT+ care coordinator. An initial assessment will be completed and the woman will

be enrolled into the PAT+ program. In Pinellas, 91% of all pregnant women and 98 % of all newborn infants are screened for risk factors and those who volunteer to receive home visiting services are assigned by the PinCHD intake unit to the most appropriate program based on their identified risks. The PAT+ team will become the preferred program for drug using women and drug exposed infants who are involved in the child welfare system.

Complementing referrals to existing home visiting programs from HS prenatal and infant risk screening, this project will also receive referrals from the Pinellas Adult Drug Court (PADC). The PAT+ team will take referrals from the PADC for families who are receiving services through the Pinellas child dependency system if the child has not been removed, and the parent(s) is a participant in drug treatment. There are currently more than 1,600 clients participating in the PADC annually. The presiding judge for the Sixth Judicial Circuit has agreed to incorporate voluntary participation in the program in the sentencing phase. WestCare will also help identify Drug Court clients with children (0-3) who are not already receiving home visiting services and make referrals to PAT+. WestCare receives funding from the Edward Byrne Memorial Justice Assistance Grant to position a WestCare counselor in the Judge's court on days in which Drug Court occurs. If the defendant wants to participate, the Judge will incorporate participation into the sentencing and will immediately ask the WestCare counselor to meet with the defendant and begin the enrollment process. A PAT+ parent educator will be assigned to the participant to help create buy-in from family members. An incentive plan will be developed by project stakeholders to engage and encourage participation from all family members. Currently, the Drug Court offers no services to the children and families of Drug Court clients. The presiding Judge and all project stakeholders want to address this gap with PAT+ funding.

When a Drug Court client, who is pregnant or has at least one child age 0-3 (who remains in the custody of the parent), is identified by the WestCare Criminal Justice Counselor, the Drug Court Judge will invite the client to participate in the PAT+ project. If the client agrees, the Judge will refer the client for an initial assessment or assign an in-court WestCare Counselor to assess the client using the Healthy Start Initial Assessment Tool. Based on the results of the Initial Assessment, a Pinellas PAT+ home visitor will be assigned to the Drug Court client. The goal of the PAT+ multi-disciplinary team is to develop a therapeutic alliance with all members of the family in the household. The team will provide care coordination for the child and family.

Drug Court clients will be admitted into the PAT+ program if the following criteria are met: 1) Individual is a client of the Pinellas Adult Drug Court and of WestCare; 2) Individual is pregnant or has at least one child (age 0- 3) voluntarily agrees to participate in the program and share information; 3) Individual grants permission for the parent educator to visit her home, engage the family and share information; 4) Individual and family (household) have a shared desire to participate in the program for 18 months to two years; and 5) The child resides in the home with the parent.

Referrals may also come from the child's medical provider. The PAT+ parent educator will ensure that every participating child has a medical home and appropriate immunizations. The PAT+ parent educator will ensure each child/family is referred to a primary care physician if they do not have a medical home and will help the family apply for Florida KidCare, if necessary.

Retaining Families

In year one, PAT+ will serve 120 pregnant women and families (unduplicated) and 125 children ages 0-3 (unduplicated). Siblings, ages 4-5, or children who age out will also be served with the PAT curriculum for 3-5 year olds by certified 3-5 PAT educators.

The PAT+ program is designed to provide at least two years of services to families between pregnancy and kindergarten entry. Families will sign a contract agreeing to receive PAT+ services for at least two years. Duration of services refers to the affiliate's overall design. The first eight visits of the new PAT curriculum concentrate on rapport building to increase retention. Optimally, the family will enroll prenatally or shortly after birth but they can enroll when their child is any age prior to age three years. When the child is older at enrollment, the parent educator will typically plan more frequent visits to have greater effect. The program will strive to enroll the maximum number of families prenatally, or shortly after the baby's birth. To assist with retention, PAT group meetings will include speakers from Job Corp, Pinellas Opportunity Council, Wealth Building Coalition of Pinellas to educate attendees on topics such as financial literacy, women's survival skills, and other appropriate topics. Additionally, client satisfaction will be evaluated using the Healthy Start Satisfaction Survey and results will be reviewed in the Healthy Start QI committee.

Recruiting, Hiring, and Retaining Staff

The federal government did not continue funding for the Even Start program due to budget deficits. This creates an opportunity to hire fully trained and certified PAT parent educators who have been working in that program for several years. These individuals have college degrees and an average of four years of experience using the PAT curriculum. The Even Start supervisor has a BA degree in elementary education, graduate courses in early childhood and five years of experience supervising a PAT team. The three PAT parent educators and their supervisor were trained in the PAT Foundation curriculum in April 2011, and will complete the on-line training requirement in July 2011. Advertisements to recruit two other PAT parent educators and a clerk will begin in July with an anticipated start date 45 days after the grant is awarded. Selected individuals must meet the minimum standards of the position to be employed. References, criminal background checks and fingerprints will be checked prior to hiring. Pre-service and on-going training, open communication, frequent supervision and support from the team will aid in retention of staff. In accordance with PAT Quality Assurance Guidelines, PAT parent educators will receive minimally two hours monthly of individualized reflective supervision and two hours of collective training monthly.

To ensure viability and continuity within the project, the Project Director and PAT+ Supervisor will provide cross training to project staff members. Two additional PinCHD staff (countywide) will be trained in the PAT curriculum to ensure continuity of care and fidelity to the model if there is staff turnover. Staff will be trained on the responsibilities of other staff so that when there is staff turnover or changes in project leadership, gaps can be successfully filled until new staff is hired or existing staff are promoted into open positions. If a pivotal position should become vacant, the Project Director will notify the DOH within 24 hours and the entire Coalition will help market and recruit for the vacant position. If the program is successful, in the absence of continued funding, the HSC will try to leverage other funding to sustain the PAT+ team.

ASSURANCES

This home visiting program is designed to result in positive participant outcomes described in the legislation: voluntary home visiting services to low income pregnant women and families with young children to reduce abuse and neglect; improve school readiness, prenatal health, child health and development, and family economic self sufficiency.

Eligible women who complete the Healthy Start risk screening are asked on the screening form if they consent to participate. In Pinellas Adult Drug Court, women will be given the option of participating in the voluntary PAT+ program or accepting other court ordered options.

Enrollment will be voluntary and services will be provided based on individualized assessments

Potential participants will be screened and services provided based on individualized assessments. The Initial Assessment by the PAT parent educator will include questions about substance use. Tools used in the assessment process include the HS Initial assessment and ASQ3, ASQ-SE, Perceived Stress Scale, Edinburgh Depression Screening, Domestic Violence Screening, and Adolescent Adult Parenting Inventory. Services will be provided based on the needs identified in the assessments. Children with abnormal screenings will be referred for further developmental assessments to the Part C community provider, West Central Early Steps. A Plan of Care will be developed with the PAT+ families to determine individual needs of the adult and children, set family goals together, to determine steps necessary to achieve them, and to monitor them. A Family Support Plan may be used to document the family's goals.

The PAT+ team will accept high risk populations who agree to participate for two years. Memoranda of Understanding with community agencies will clarify that PAT+ participants will be given priority for services including drug treatment (with appropriate funding), access to subsidized childcare slots, mental health services, and other wrap-around services.

OBTAINING OR MODIFYING THE DATA SYSTEM FOR CONTINUOUS QUALITY IMPROVEMENT

The HSC is committed to the adoption of an evidence-based home visiting curriculum and to work with the DOH and the evaluation team to establish a data collection process for the required data. While PAT has data collection requirements in place, strategies for collecting and reporting the required data to meet the federal requirements will depend upon the variables to be measured and the decisions made by the program evaluator. Through a collaborative effort with community partners, the DOH and the evaluation team, as well as consent from program participants, the benchmark data and respective constructs will be identified and collected in a data system. This data collection and management methodology will be developed in consultation with the HSC, PAT State Office, and the National PAT Office. A sustained effort will be necessary to provide on-going staff training and supervision of data collection.

ESTIMATED TIMELINE

Because the majority of staff have already been identified and trained it is anticipated that the PAT + Program can reach the program capacity of 120 families by January 2012.

Table 4.2

Action Step	Start Date	End Date
1. Notice of Award (Estimated)	May 16, 2011	
2. Notify Partners of Award	May 16, 2011	May 23, 2011
3. Establish separate grant accounting	May 16, 2011	June 26, 2011
4. Begin developing MOU		By June 30, 2011
5. Contract Execution with start date		July 1, 2011
6. Program Implementation Planning Mtg.	May 16, 2011	July 14, 2011
7. Order equipment, furniture, phones and supplies	May 16, 2011	July 21, 2011
8. Contract with school system for PAT supervisor and 3 parent educators	May 16, 2011	July 14, 2011
9. Finalize policies & procedures	May 16, 2011	July 21, 2011
10. Develop program brochure		Within 3 weeks
11. Recruit and hire additional staff	May 16, 2011	August 15, 2011
12. Criminal background checks for new hires	May 16, 2011	August 15, 2011
13. Provide Staff Orientation/Pre-service training including HIPAA, FERPA, Human Rights Protection, Motivational Interviewing, substance misuse, HMS, use of screening tools etc.	May 16, 2011	September 1, 2011
14. Order necessary materials and supplies	May 16, 2011	August 1, 2011
15. Establish MOU's with partners	May 16, 2011	September 1, 2011
16. Send newly hired staff to PAT Training Institute & certification	May 16, 2011	September 1, 2011
17. Finalize data collection procedures	May 16, 2011	May 30, 2011
18. Finalize evaluation procedures	May 16, 2011	May 30, 2011
19. Schedule additional substance abuse training for PAT Team	May 16, 2011	July 5, 2011
20. Schedule domestic violence training for PAT Team	May 16, 2011	July 5, 2011
21. Accept client referrals	May 16, 2011	July 5, 2011
22. Begin to recruit parents for HV Advisory Committee	May 16, 2011	August 16, 2011

23. Facilitate first Home Visiting Advisory Committee	May 16, 2011	August 16, 2011
24. Solicit feedback from stakeholders		Ongoing
25. Estimated time caseload capacity reached		January 2012
26. Report data (GPRA/TRAC)		Ongoing
27. Evaluate the program	June 2012	July 2012
28. Apply for Year Two funding (if available)		As applicable

ESCAMBIA COUNTY

ENGAGING PARTICIPANTS

Families Count is creative in its approach to finding solutions for high-risk families. A partnership has been established with the University of West Florida psychology department to work with high-risk children. Bay Area food bank provides food for families at group events, Baybridge Insurance Company promotes Florida KidCare in their daily work, Walmart donates items for identified families to ease budget stress, and Gulf Power Foundation donates dollars for utility subsidies, etc.

Established MOUs with community partners will assist in the identification of families most likely to be eligible for services. Families are identified in one of three ways: through the Prenatal Risk Screen, in the birthing facility, or through a community referral. Families Count receives all Prenatal Risk Screens for the service area. In the event of a self-referral, a provider referral, or identification at a birthing facility, the HFF Record Screen/Referral Form is completed using the same questions that are on the Prenatal Risk Screen to identify women who have risk factors for child abuse and neglect and need further assessment to determine program eligibility. These factors include educational status, marital status, number of children in the home who are younger than age five or have special needs, signs of maternal depression, domestic violence, income security, substance use including alcohol and tobacco products, and maternal age and trimester in which prenatal care began. Women who score four or more points on the screen are offered an assessment by a Family Assessment Worker (FAW).

The FAW is a trained professional who engages the mother and the father/significant other (if available) to talk about themselves, their family and life experiences that may put their child at risk of abuse and neglect. The FAW uses the Healthy Families Florida Assessment Tool (HFFAT). Scoring of the HFFAT is based on 40 subject areas covered during a one hour conversation that include but are not limited to: economic security, social isolation, substance use, family violence, poor mental health, maternal depression, family history of abuse and limited knowledge of parenting skills. The first home visit should occur within 30 days of the assessment. The family must enroll before the child is three months old. Due to this comprehensive assessment process, the home visitor is able to immediately tailor services specific to the family's needs, to better engage the family and keep them interested in the program.

Families Count is proposing to serve seventy five (75) families with this expanded Healthy Families home visiting program in the first year of operation or a caseload ratio of 1 to 15 per family support worker. It is expected that 125 families will be served in the second year or a case load ratio of 1 to 25 per family support worker.

Participant Satisfaction Surveys are conducted annually in the month of October. Surveys are distributed annually to all participants with envelopes addressed to Healthy Families Florida for anonymity. HFF compiles the results and sends a report of the participant satisfaction level back to Families Count along with the survey data results.

RECRUITING, HIRING, AND RETAINING STAFF

Healthy Families Escambia is committed to Equal Employment Opportunity and Affirmative Action in employment. If the position is new, the program manager develops a job description. For both new and replacement positions, the program manager notifies the Families Count Corporate Office. The Corporate Office posts a Job Opportunity Bulletin for five (5) days internally at Families Count. If necessary, Families Count advertises in local newspapers or on-line via the web. All resumes and applications are received and reviewed by the Healthy Families Program Manager at Families Count. The program manager conducts phone and personal interviews with the most promising candidates. Selected staff members then interview the candidates to ensure compatibility with the team, and a candidate is chosen. After reference checks, criminal background and drug screenings are completed, the candidate is offered the position by the Families Count Executive Director. Orientation for the new employee is scheduled, and a ninety day (90) performance review of the employee is conducted by the program manager.

Supervision of Staff

The HFA model and HFF require extensive training so that staff has the knowledge and skills they need to improve the outcomes of the high-risk families we serve. Home visitors receive intensive, individual supervision (90-120 minutes per week) from a degreed professional that includes systematic reviews of the families being served. Supervision includes discussing the families' progress towards achieving goals, how the home visitor is working with the family to reduce their risk factors, discussing interactions between the parents and the children, and providing skill development and professional support. Each Family Support Worker (FSW) has at minimum, a supervisory session at a regular scheduled time each week. The ratio of supervisor to staff does not exceed one supervisor for every six staff members. The Family Assessment Worker receives ongoing supervision from the Family Assessment Worker Supervisor (FAWS) and at Families Count; this position is currently filled by the Healthy Families Program Manager. Each assessed case is reviewed for program acceptance and assignment. The Program Supervisor receives supervision at least monthly by the Program Manager to ensure continuity and effectiveness of service to all families.

ASSURANCES

The services described earlier explain how the program is designed to result in most of the participant outcomes required in the legislation. While not all outcomes have been measured,

Families Count is confident these outcomes will be met because of the training, supervision and quality assurance built into this program.

The HFA model requires that "program policy, procedures and practices ensure services are offered to families on a voluntary basis." During the first home visit, the family signs the Participant Agreement and Rights form. The form states, "I understand the program is voluntary and I would like to participate in Healthy Families." It also states that participants have the right to refuse participation in Healthy Families at any time. Supervisors and staff from the HFF Central Office review the participant files to ensure every family that enrolls has signed this form.

Healthy Families Escambia will enroll families that are eligible for services using the HFF Assessment Tool described earlier. It is expected that the majority of the clients will meet the priority requirements specified in the legislation.

Obtaining or Modifying the Data System for Continuous Quality Improvement

Families Count is committed to the adoption of an evidence-based home visiting curriculum and to work with the DOH and the evaluation team to establish a data collection process for the required data. Healthy Families Florida has a statewide, comprehensive data management system already in place, and the HFF Central Office is willing and able to modify their data management system to collect and report on each of the required individual level data elements for this grant and will provide the data directly to the DOH evaluator in mutually agreeable terms.

Strategies for collecting and reporting the required data to meet the federal requirements will depend upon the variables to be measured and the decisions made by the program evaluator. Through a collaborative effort with community partners and consent from program participants, the benchmark data and respective constructs will be identified and collected in a data system. The DOH and the evaluation team will develop the data collection and management methodology in consultation with the Healthy Families, HFF Central Office, and Healthy Families America.

Estimated Timeline

Families Count will receive prenatal screens for the expanded service area beginning in July 2011 to ensure a pool of families to contact once an assessment worker is hired. One of the greatest challenges of expanding services to an existing site is the amount of time it takes to begin serving the additional families by competent staff. However, given the demands of this grant as well as the intensive training required by the model, a timeline has been developed to guide the hiring process to ensure that the program is prepared to begin enrolling families by October 1, 2011.

Table 4.3

Action Step	Start Date	End Date
1. Advertise supervisor position	June 20, 2011	July 1, 2011
2. Advertise home visitor and assessment worker positions	July 5, 2011	July 22, 2011
3. Review resumes and conduct interviews for supervisor position	July 11, 2011	July 11, 2011
4. Extend job offer to qualified applicant for supervisor position	July 25, 20011	July 25, 2011
5. New program supervisor employment start date	July 25, 2011	
6. Review resumes and conduct interviews for assessment worker position	July 25, 2011	July 29, 2011
7. Review resumes and conduct interviews for family support workers positions	July 25, 2011	August 5, 2011
8. Extend job offer to qualified applicant for assessment worker position	August 1, 2011	
9. Extend job offer to qualified applicants for family support workers positions	August 8, 2011	
10. New assessment worker employment start date	August 15 2011	
11. FAW Core: required for assessment worker; recommended for supervisor	August 16, 2011	August 19, 2011
12. New family support workers and high risk specialist employment start date	August 22,2011	
13. FSW Core: required for family support workers and supervisor; recommended for assessment worker	August 29, 2011	September 2, 2011
14. FSWS Core: required for supervisor	September 13, 2011	September 15, 2011
15. GGK: required for family support workers and supervisor	September 19, 2011	September 22, 2011

The above hiring timeline takes into consideration the desire to include the supervisor in the hiring process of the assessment worker and family support worker. The time frame suggested above is designed around the latest hire dates possible to still receive the required pre-service trainings in time before the October 1st deadline for beginning to enroll families. The dates for trainings are scheduled for mid-August to mid-September. The project plans to begin assessing families in early September. This timeline allows for the assessment workers to shadow the existing Healthy Families Program to help better prepare staff for their role.

The HFA model allows for up to 25 families per family support worker; it limits the number to a maximum of 15 families on the most intensive level of services (level 1) and also requires that families stay on level 1 for a minimum of six months after the birth of the baby. Therefore, it is estimated that it will take approximately four months (February 1, 2012) to reach level 1

capacity, defined as 15 families at the most intensive level per family support worker. This estimate is dependent upon the number of births that assess appropriate for the program and the subsequent percent of families who volunteer for services.

DUVAL COUNTY

ENGAGING PARTICIPANTS

Identification of eligible families for the NFP project will be incorporated into the existing Northeast Florida Healthy Start Coalition (Coalition) screening and referral system in Duval County. Self-referrals and referrals from partner agencies are also accepted in the current system. Parents will be recruited through the NFP program, as well as existing grass-roots engagement activities sponsored by the Coalition and its community partners (i.e. PhotoVoice, Make a Noise! Make a Difference!). Following completion of initial contact by Healthy Start staff, eligible families will be linked to NFP for ongoing home visiting services. The NFP project will serve 100 families in Duval County. This is based on a caseload cap of 25 per nurse for the four-nurse team.

Retaining Families

Participant retention strategies will be integrated into all service delivery activities. While incentives will be offered to families, experience indicates that the most significant factor impacting retention is the bond formed between the nurse home visitor and the family. Staff recruitment will focus on hiring nurses who are not only educationally qualified, but also have personality traits and skills that will facilitate the bonding process. This approach to staff recruitment has been successfully used by the Coalition in both the Magnolia and Azalea Projects. Both of these projects have low staff turnover and successfully retain participants in service for 18 months or more. Staff training and reflective guidance will be used to support the nurse home visitors and their efforts to retain participants.

RECRUITING, HIRING, AND RETAINING STAFF

The Coalition will subcontract with the Duval County Health Department and Shands Jacksonville to provide staff for the team and implement the NFP model in selected priority areas of the city. Each agency has an established recruitment and hiring process. Current staff will also be given an opportunity to apply for the nurse home visitor and supervisor positions. The Coalition will hire data entry staff and provide administrative and fiscal oversight of the project. The organization chart for the proposed NFP program in Duval County is also included in Appendix 6.

ASSURANCES

The MIECHV benchmarks will be met by consistently utilizing the NFP curriculum and adhering to program guidelines, and by integrating the program into the existing continuum of home visiting services in Duval County. This integration will ensure that NFP has access to the established array of referral agencies currently used by Healthy Start providers.

Families who choose not to participate in the voluntary program, or who are identified after the program reaches capacity, will be referred as appropriate to another agency within the home visiting continuum.

Priority will be given to low-income, first-time mothers at highest risk (teens, history of substance abuse or tobacco use, low student achievement), as well as expectant military families at the Naval Hospital Jacksonville. Eligible families who reside in three areas of the county: New Town Success Zone and the surrounding community (Health Zone 1), Arlington (Health Zone 2) and Westside/SW (Health Zone 4) will also be considered priority participants.

As described above, the Northeast Florida Healthy Start Coalition is responsible for the planning, funding and oversight of the county's largest and most experienced system of home visiting services. This multi-agency system has successfully impacted poor birth outcomes and child health and well-being in Duval County. It has the capacity to support, implement and successfully integrate the evidence-based NFP model into this system of care. The Coalition and its partner agencies have a well-developed network of community referral agencies that can assist in addressing the complex needs of the high-risk families.

Obtaining or Modifying the Data System for Continuous Quality Improvement

The Coalition and its NFP partner agencies are committed to the adoption of an evidence-based home visiting curriculum and to work with the DOH and the evaluation team to establish a data collection process for the required data. While NFP has data collection requirements in place, strategies for collecting and reporting the required data to meet the federal requirements will depend upon the variables to be measured and the decisions made by the program evaluator. Through a collaborative effort with community partners and consent from program participants, the benchmark data and respective constructs will be identified and collected in a data system. The DOH and the evaluation team will develop the data collection and management methodology in consultation with the Coalition and the National NFP Office.

The NFP National Office has extensive experience working with state entities on program implementation and evaluation. NFP sites collect a minimum data set specified by the NFP National Office and enter it into the Efforts to Outcomes (ETO™) web-based software which offers a robust data collection and reporting system that provides information about client interaction, program implementation and program outcomes. These data are collected on each client; sampling is not used. The National Office is working to align its data set to ensure measures are available to meet all MIECHV requirements.

Estimated Timeline

The timeline for implementation of the NFP program in Duval County is outlined below. Pre-implementation activities will begin as soon as the contract is signed with the Florida Department of Health. The NFP National Program Office will provide the Coalition with detailed guidance on required activities to ensure a successful start-up. Staff will be recruited, hired and trained by mid-September, 2011. No problems are anticipated to enrolling initial participants by October 1, 2011 and the program is projected to achieve capacity in nine months.

Table 4.4

Action Step	Start Date	End Date
1. DOH contract finalized, signed	July 1, 2011	July 31, 2011
2. Subcontract with DCHD, Shands finalized, signed	July 1, 2011	July 31, 2011
3. NFP Implementation plan completed, submitted to NFP National Office	July 1, 21011	July 31, 2011
4. Staff positions finalized, posted	July 1, 2011	July 31, 2011
5. Coordinate data collection activities with state evaluator	July 1, 2011	August 31, 2011
6. Weekly NFP team meetings	July 1, 2011	September 30, 2012
7. Weekly meeting of Leadership Team	July 1, 2011	September 30, 2012
8. MOUs negotiated with community partners	July 1, 2011	September 30, 2011
9. Ongoing TA from National Office	July 1, 2011	September 30, 2012
10. Work with National office, HS agencies, DOH to identify ongoing sources of support	July 1, 2011	September 30, 2012
11. Feedback and finalization of implementation plan	August 1, 2011	August 31, 2011
12. NFP staff interviewed, hired	August 1, 2011	August 31, 2011
13. Proprietary Protection letter signed and submitted to National Office	August 1, 2011	August 31, 2011
14. NFP local offices established, supplies, equipment purchased	August 1, 2011	August 31, 2011
15. Changes made to agency policies, protocols to align with NFP model	August 1, 2011	August 31, 2011
16. Travel arrangements, registration for NFP training	August 1, 2011	August 31, 2011
17. Review of orientation packet with National Office	September 1, 2011	September 30, 2011
18. NFP staff completes self-study materials	September 1, 2011	September 30, 2011
19. Staff attends Denver training, completes core training	September 1, 2011	September 30, 2011
20. ETO licensure, data systems training	September 1, 2011	September 30, 2011
21. Regional processing staff oriented to NFP and referral criteria on HS prenatal screen	September 1, 2011	September 30, 2011
22. Duval HS Coordinating Group membership expanded to form HV Advisory Council	September 1, 2011	October 31, 2011
23. Marketing campaign, program announced	October 1, 2011	October 31, 2011
24. Participant enrollment initiated	October 1, 2011	October 31, 2011
25. Quarterly DOH contract deliverables, reports	October 1, 2011	September 30, 2012
26. Nurse home visits implemented	October 1, 2011	September 30, 2012
27. Weekly case conferences	November 1, 2011	September 30, 2012
28. Individual staff supervision	November 1, 2011	September 30, 2012

29. Supplemental professional development	November 1, 2011	September 30, 2012
30. Monthly HV Advisory Council meetings	November 1, 2011	September 30, 2012
31. Review NFP-provided program reports	November 1, 2011	September 30, 2012
32. Adjust program implementation to assure fidelity with model	November 1, 2011	September 30, 2012
33. Develop and implement sustainability plan	January 1, 2012	September 30, 2012

SUMMARY OF THE IMPLEMENTATION PLAN

While the MIECHV Program has yet to be implemented, efforts by the state and county level administrators, in concert with the local community organizers in the short amount of time required to write the updated state plan, fully demonstrate Florida's passion and commitment to providing quality services to our most vulnerable citizens in an organized, thoughtful, and effective manner.

As documented in the subsequent sections, administrators at the local, state, and national levels will work collaboratively to ensure successful implementation of the MIECHV Program at all levels identified in the logic model described in Section 2. The Program Team brings decades of experience to the table in program implementation, evaluation, training, and technical assistance allowing for a strong organizational capacity to support Florida's Home Visiting Program. Likewise, each of the communities demonstrates the ability to hire, train, and supervise competent staff to work with the HV families.

SECTION 5: PLAN FOR MEETING LEGISLATIVELY-MANDATED BENCHMARKS

Florida's MIECHV Program evaluation will collect and analyze program implementation and child and family outcome data for three purposes: (1) to measure the success of the program; (2) inform and help communities in developing and implementing home visiting models and (3) to allow state administrators to provide technical assistance and continuously improve the quality of Florida's program.

The Florida Department of Health by, July 1, 2011, will retain an evaluation team to lead the evaluation efforts. The team will work closely with community implementers and agency staff to ensure that the evaluation and data reporting meet federal reporting requirements as well as the state's and communities' needs for information for Continuous Quality Improvement (CQI) efforts.

Activities during the start-up years will focus on building evaluation infrastructure and process evaluation of early implementation that can serve as a basis for successful implementation and continued evaluations of Florida's system.

DATA SOURCES

Web-based Case Management System

The web-based case management system will have the capacity to guide a home visitor through the various assessment tools for the development of a well-integrated case management plan. In addition, it will provide reminders to home visitors regarding necessary follow-up activities with their clients and to record services provided, referrals made, and referrals completed. It will give home visitors the tools they need for effective case management, while providing useful reports for supervisors, evaluators, and centrally located agency staff to guide the provision of technical assistance that will support CQI.

This system will contain web-based versions of all the assessment tools that will be used to assess characteristics and needs for families being served, and it will collect data for benchmark indicators that will be obtained through direct interactions with families. The web-based case management system will serve as a data source for benchmark indicators as well as for monitoring process indicators, such as local model enrollment and retention rates, for the community and for individual home visitors. It will be an ongoing challenge to maintain model fidelity while collecting the additional data required to report indicators for every benchmark construct.

The system will capture data required by Florida's MIECHV Program and by each of the national offices of the home visiting programs being implemented. Agreements will be forged with national offices to regularly upload required data elements to the national systems. Likewise, data will also be uploaded on a regular basis into the Comprehensive Birth Registry System described below.

Although every effort will be made to ensure that the web-based case management system is comprehensive before it is used, undoubtedly, based on input from home visitors, supervisors, agency staff and evaluation team analysts, modifications will be made to the system. Those modifications will be documented and included in any reports based on data collected.

COMPREHENSIVE BIRTH REGISTRY SYSTEM

The Comprehensive Birth Registry (Registry) system will be a proprietary database that will: be available to the evaluation team as specified by data use agreements and IRB; capture detailed case-level data on all births in the regions providing services for system participants thus allowing for a comparison group (or groups) that is demographically similar but not receiving home visiting services; import data from the web-based case management system and administrative data sources; and provide unrestricted capability for generation of ad hoc reports. Importing into the Registry the Florida birth certificate data for all births in communities offering MIECHV services will make possible comparisons of study families (1) to all families with newborns in their region, (2) to all demographically similar families, or (3) to particular families selected based on particular characteristics (e.g., mother's education level, race/ethnicity, use of Medicaid) to create a matched comparison group. Depending on the research question, different statistical analyses are appropriate and should be possible with the Comprehensive Birth Registry System. To the extent that post-delivery data can be imported from administrative sources for many of these children, the number of questions that can be answered via the Registry will be increased.

The comprehensive birth registry will be used to analyze data for all constructs as required by HRSA, quarterly process reports to agency staff for CQI purposes, and comparisons between program participants' outcomes and expected outcomes or outcomes for a matched comparison group.

Release forms will be sought from all families receiving services to ensure maximum availability of data for analysis. However, in order to obtain identified data to populate the birth registry, detailed data use agreements will have to be forged with several different state agencies. Therefore, data available for analysis may be limited based on the nature of those data use agreements.

Qualitative and Non-Identified Data Sources

Qualitative data about program implementation will be acquired from several sources. To document and evaluate state-level implementation, meeting summaries and other documents will be reviewed, analyzed, and summarized using the state plan as a benchmark for implementation progress. To supplement data collected from community implementers in the web-based case management system, reporting templates will be created quarterly and implementing communities will be required to complete and submit the template to the evaluation team. The evaluation team will then combine the two data sources, analyze the data, and prepare quarterly reports for agency staff that will serve as the basis for conversations with community implementers, technical assistance efforts, and CQI.

Further analysis will be based on three additional sources of data: (1) annual administration of a customer survey exploring client satisfaction with services as well as client perceptions related

to the degree of collaboration among system providers; (2) the CDC's PARTNERS survey will be used annually in all communities implementing MIECHV to provide information about how providers in the local system perceive the level and effectiveness of collaboration; and (3) the evaluation team, in collaboration with agency staff, will conduct annual site visits focused on assessing the communities' adherence to the terms of their contracts, verifying content of quarterly reports, and collecting information about how the state system should be modified to make the program more effective. Data at site visits will be obtained through a combination of record review, structured interviews and/or focus groups. The exact nature of what will be collected and the method of collection will be determined in collaboration with community partners to ensure that the resulting information is informative and useful to community implementers.

When it is not possible for the evaluation team to obtain identified administrative data from state agencies (privacy concerns will likely limit some data elements), arrangements will be made to obtain aggregate data for families receiving treatment and the matched comparison group. For some outcome variables obtained via administrative data, the most feasible comparison may be between program participants' scores and expected values for those scores based on census tract data. (See the section entitled Measuring Outcomes Using Comparison Groups and Expected Values below).

MEASURING BENCHMARKS AS REQUIRED BY HRSA

To reduce the burden on home visitors and to maximize the time they can devote to building a trusting relationship with families during the first months of service provision, tools for assessment of client status have been selected using the following criteria:

- When identified data can be obtained from an administrative source, they will be.
- Assessment tools should be validated whenever possible.
- Assessment tools should be easy for home visitor to use (e.g., minimal training required).
- If the Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire addressed the indicator, that instrument was given preference.
- Status should be assessed using the fewest number of questions and the fewest number of assessment tools.

For some constructs, more than one indicator will be collected to maximize the chance that we will be able to see an improvement resulting from home visiting services. For some indicators data may be difficult to obtain or there may be few families for whom the indicator can be measured. Those indicators will be tracked but probably not reported and are labeled on the chart below.

Even though the home visiting models being implemented were selected because they are "evidence-based," we note that evidence does not exist in the literature indicating that each model has an effect on every construct required to be measured. When we report results in the future, therefore, we will include a table clearly stating, based on the models implemented, the constructs where an effect is expected based on published studies, other constructs where an effect has not been previously reported but may be expected, and, finally, constructs where an

effect is probably not expected. It will be instructive to measure all constructs for Florida's program and for each model implemented by Florida communities to add to the body of evidence, but, based on published studies, an effect on many constructs is not expected.

Since Florida's ability to report benchmark constructs relies heavily on home visitors conducting timely and accurate assessments and recording the results of those assessments in the web-based case management system, partnerships will be forged with local program implementers before final decisions are made about who will record data and under what circumstances. These partnerships will focus on collection of meaningful, timely and reliable data while maintaining model fidelity. All home visitors and other staff will have to be adequately trained to ensure appropriate use of the web-based case management system for conducting assessments, developing case plans, and recording services provided. Because a high proportion of Florida residents have Spanish as the primary language spoken in the home, when available, assessment tool will be incorporated in the web-based case management system in Spanish as well as English.

Table 5.1: Measurement of Benchmark Constructs

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Prenatal Care	Percent of mothers receiving adequate prenatal care. [+] **Calculation:** The adequacy of prenatal care will be calculated for each mother for two time periods – before and after she began participating – by dividing the number of prenatal care visits she had in the time period by the recommended number. For women who begin receiving services during pregnancy (# who received adequate prenatal care after inception of services/ # women who begin receiving services during pregnancy) minus (# who received adequate prenatal care prior to inception of services/ # women who begin receiving services during pregnancy) Adequacy will be defined as receiving 80% or more of the number of visits using ACOG recommendations.	By September 30, 2013, for women beginning home visiting services during pregnancy, a higher percentage of women will receive adequate prenatal care (Based on American College of Gynecology and Obstetrics Standards) after they begin receiving home visiting services than before they entered the MIECHV program.	Web-based case management system	Because the rates of recommended prenatal visits vary across the nine-month pregnancy period, this analysis compares ratios of made visits to recommended visits. This indicator relies on mothers' self report detracting somewhat from validity, although this limitation equally affects mothers' reports for both time periods. This indicator has face validity for the construct.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Prenatal Care (cont.)	**Track but do not report:** Percent of mothers beginning prenatal care during the first trimester.* **Calculation:** of women who become pregnant while receiving services, the number who began prenatal care during the first trimester / # women who become pregnant while receiving services	By September 30, 2013, a higher percentage of women who become pregnant while receiving services will begin prenatal care during the first trimester compared to the percentage of women with similar demographics.	Vital statistics and web-based case management system	This indicator relies on mothers' self report at the time of birth detracting somewhat from validity. However, the data have been recorded in the same manner for more than ten years so whatever reporting error exists should be equal over time. This indicator has face validity for the construct.
Parental use of alcohol, tobacco, or other drugs	Percent of mothers who smoke receiving smoking cessation services in the past three months. **Calculation:** # of women receiving services who smoke who received smoking cessation service in the past three months/# of women receiving services who smoke	By September 30, 2013 the percent of women receiving services who smoke that have received smoking cessation services in the past three months will be higher after receiving services for four months than at inception of services.	Web-based case management system	Two factors negatively affect the validity of this indicator: 1. With respect to services received before program inception, it relies on self report and 2. The data sources for the historical services and for services provided while the women are enrolled in the program are different.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Parental use of alcohol, tobacco or other drugs (cont.)	**Track but do not report:** Percent of mothers reporting drinking during pregnancy^ **Calculation:** Of women who begin receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant the # reporting drinking / # women who begin receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant.	By September 30, 2013, the percentage of women who began receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant who report drinking during pregnancy will be lower than the percentage of women of similar demographics reporting drinking during pregnancy derived from PRAMS data.	Web-based case management system Derived from PRAMS question 42a[a]	This indicator relies on the mothers' self report detracting somewhat from validity; the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. This indicator has face validity for the construct.
	Track but do not report: Percent of mothers smoking during pregnancy^ **Calculation:** Of women who begin receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant the number smoking during pregnancy/ # women who begin receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant	By September 30, 2013 the percentage of women who began receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant who report smoking during pregnancy will be lower than PRAMS data for women of similar demographics.	Web-based case management system Derived from PRAMS question 35[a]	This indicator relies on the mothers' self report detracting somewhat from validity, the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. This indicator has face validity for the construct.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
	Track but do not report: Percent of mothers smoking.^ **Calculation:** # women receiving services who smoke/ # women receiving services	By September 30, 2013, a smaller percentage of mothers receiving services will smoke after 12 months of services than at service inception.	Web-based case management system Derived from PRAMS question 28	This indicator relies on the mothers' self report detracting somewhat from validity; the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. This indicator has face validity for the construct.
Pre-conception care	Percent of non pregnant women receiving services using multivitamins or folic acid.″ **Calculation:** # non-pregnant women receiving services who report taking multi-vitamins or folic acid/ # non-pregnant women receiving services	By September 30, 2013, the percent of non-pregnant mothers receiving services reporting taking multivitamins or folic acid after 12 months of receiving services will be greater than the percentage of non-pregnant mothers at the inception of services.	Web-based case management system Derived from PRAMS question 3[a]	This indicator relies on the mothers' self report detracting somewhat from validity. The PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. A woman of child-bearing age receiving regular primary care is likely to be taking folic acid, especially if she has a history of irregular use of contraceptives.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Pre-conception care (cont.)	**Track but do not report**: Percent of women who gave birth while receiving services who had a post partum check up within 8 weeks of giving birth.[+] **Calculation:** # non-primiparous women giving birth while receiving services who received a post partum check-up within 8 weeks of birth/ # non-primiparous women giving birth while receiving services	By September 30, 2013, the percent of women who gave birth while receiving services who have a postpartum check up within 8 weeks of giving birth will be greater than the percent of the same group of women during their previous postpartum period.	Web-based case management system. Derived from PRAMS question L-8[b].	This indicator relies on the mothers' self report detracting somewhat from validity. The PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. Post partum care can be considered a first step in receipt of pre-conception care for subsequent pregnancies.
	Track but do not report: Percent of mothers drinking more than three drinks per week during the three months before they got pregnant.[*] **Calculation:** # women who became pregnant while receiving services who report drinking more than 3 drinks per week during the three months before they became pregnant/ # women who became pregnant while receiving services	By September 30,2013, the percent of women who became pregnant while receiving service who drink more than three drinks per week will be lower than PRAMS data for women of similar demographics.	Web-based case management system Derived from PRAMS question 41a[a]	This indicator relies on the mothers' self report detracting somewhat from validity; the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. There is less likelihood that a woman receiving regularly scheduled primary care will be drinking excessively.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
	Track but do not report: Percent of mothers smoking during the three months preceding pregnancy.* **Calculation:** # women who became pregnant while receiving services who report smoking during the three months before they became pregnant/ # women who became pregnant while receiving services	By September 30, 2013, the percent of women who became pregnant while receiving service who smoke during the three months preceding conception will be lower than PRAMS data for women of similar demographics.	Web-based case management system Derived from PRAMS question 34[a]	This indicator relies on the mothers' self report detracting somewhat from validity; the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. There is less likelihood that a woman receiving regularly scheduled primary care will be smoking.
Inter-birth intervals	Percent of mothers using contraception[+] **Calculation:** Three months after the birth of an infant the # women receiving services who are currently using contraceptives/ # women receiving services three months after the birth of an infant	By September 30, 2013, the percent of mothers receiving services using contraception three months after the birth of an infant will be greater than PRAMS data for women of similar demographics.	Web-based case management system Derived from PRAMS question 68[a]	This indicator relies on the mothers' self report detracting somewhat from validity; the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. Contraceptive use is negatively correlated with becoming pregnant.
	Track but do not report: The percent of mothers receiving services with an interpregnancy interval of less than 18 months in a subsequent pregnancy.* **Calculation:** # women who became pregnant while receiving services who have an	By September 30, 2013, the percent of women receiving services who become pregnant with an interpregnancy interval of less than 18 months will be lower than the percentage for a similar demographic	Vital statistics and PRAMS	The system captures pregnancies that end in births but not abortions and miscarriages. This indicator has face validity for the construct.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
	interpregnancy interval of less than 18 months/ # women receiving services	group.		
Screening for maternal depressive symptoms	**Track but do not report:** Percent of mothers screened for depression with positive results. **Calculation:** # women receiving services who have been screened for depression within the past three months/# of women receiving services.	By September 30, 2013, the percent of women screened for depression within the past three months will be greater after receiving home visiting services for three months than at the inception of services.	Web-based case management system	Two factors negatively affect the validity of this indicator: 1. With respect to services received before program inception, it relies on self report and 2. The data sources for the historical services and for services provided while the women are enrolled in the program are different. This indicator has face value.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Screening for maternal depressive symptoms (cont.)	Percent of mothers screened for depression within the past three months." **Calculation:** # women receiving services who screen positive for depression/ # women screened for depression	By September 30, 2013, there will be a decrease in the percent of mothers who screened positively for depression at service initiation, using the three-question depression screen published by RAND corporation, who also screen positively after receiving services for 12 months.	Web-based case management system, based on responding positively to two of the following three questions on the RAND depression screener: 1, 2A and 3a and on service records.	This modified version of the full six-question RAND screener has been used successfully in the Educare program. This should be both a reliable and valid measure in that the screening tool will be contained in the web-based system and thus its use will be automatically recorded. This indicator has face validity for the construct and for measuring improvement.
	Track but do not report: Percent of mothers who screen positive for depression who receive appropriate referral services within three months of screening. **Calculation:** # women receiving appropriate referral services for depression/#women screening positive for depression	By September 30, 2013, the percent of women receiving appropriate referral services for depression will be greater three months after screening for depression than one month after screening positive for depression.	Web-based case management system, based on responding positively to two of the following three questions on the RAND depression screener: 1, 2A and 3a and on service records.	This modified version of the full six-question RAND screener has been used successfully in the Educare program. This should be both a reliable and valid measure in that the screening tool will be contained in the web-based system and thus its use will be automatically recorded. This indicator has face validity for the construct and for measuring improvement.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Breastfeeding	Percent of mothers breastfeeding for at least two months.* **Calculation:** of mothers who began receiving services during or before the third trimester the # who breastfeed for at least two months/ # mothers who began receiving services during or before the third trimester	By September 30, 2013, the percent of mothers who began receiving services during or before the third trimester of pregnancy who breastfeed for at least two months will be greater than PRAMS data for women of similar demographics.	Web-based case management system based on PRAMS question 61[a]	Although this indicator relies on the mothers' self report detracting somewhat from validity, the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. This indicator has face validity for the construct.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Well-child visits	Percent of children being served with a well baby check-up.[>] **Calculation:** # children receiving services who receive well baby checkups/# children receiving services	By September 30, 2013, the percent of children receiving services that have had a well-child check-up in the past two months will be greater after two months of receiving home visiting services than at the inception of services.	Web-based case management system based on PRAMS question 66[a]	At the beginning of each visit, the home visitor will ask if the child has been to the doctor since the last visit and, if so, for sickness, injury, or well-child visit. This indicator is not as reliable as administrative data as it relies on parental report. This indicator has face validity for the construct. This indicator is not intended to measure the adequacy of the number of visits based on the child's age, but the intent is to measure that they are accessing some primary care. Two factors negatively affect the validity of this indicator: 1. With respect to services received before program inception, it relies on self report and 2. The data sources for the historical services and for services provided while the women are enrolled in the program are different.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Maternal/Child health insurance status	Percent of children with health insurance.[=] **Calculation:** # children receiving services with health insurance/ # children receiving services	By September 30, 2013, when families begin services after the birth of a child, a higher percentage of children will have health insurance 3 months after the inception of services than at the inception of services.	Web-based case management system derived from a modified version of PRAMS question 2[a]	This indicator relies on the mothers' self report detracting somewhat from validity; the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. This indicator has face validity for the construct.
	Track but do not report: Percent of mothers with health insurance.[=] **Calculation 1 – non-pregnant:** # non-pregnant women receiving services with health insurance/ # non-pregnant women receiving services **Calculation 2 -- pregnant:** # pregnant women receiving services with health insurance/ # pregnant women receiving services	By September 30, 2013, the percent of mothers receiving services who had health insurance after 3 months of receiving services will be greater than the percentage at the inception of services, separately measured by pregnancy status.	Web-based case management system derived from a modified version of PRAMS question 2[a]	Although this indicator relies on the mothers' self report detracting somewhat from validity; the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. In addition, validity can be verified for mothers covered by Medicaid by comparing the Mothers' responses to Medicaid data. This indicator has face validity for the construct.

Benchmark Area 2: *Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Child visits to the emergency department (all causes)	Percent of children receiving services with referrals to a medical home in the past two months. **Calculation:** # children receiving services with referrals to a medical home in the past two months/# children receiving services.	By September 30, 2013, the percent of children receiving services with a referral to a medical home within the past two months will be greater after receiving home visiting services for two months than at the inception of services.	Web-based case management system	Two factors negatively affect the validity of this indicator: 1) With respect to services received before program inception, it relies on self report; and 2) The data sources for the historical services and for services provided while the women are enrolled in the program are different.
	Track but do not report: Percent of children with emergency room visits[>] **Calculation:** # children receiving services with an emergency room visit within the past 3 months/ # children receiving services	By September 30, 2013, for children who were at least 3 months of age at the inception of services the percent with emergency room visits in the past three months will be greater at the inception of services than after twelve months of receiving services.	Florida Agency for Health Care Administration, perhaps through data they already supply to the Department of Health	This indicator is both valid and reliable. This indicator has face validity for the construct.

Benchmark Area 2: *Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Mother visits to the emergency department (all causes)	Percent of women receiving services with referrals to a medical home in the past two months. **Calculation:** # women receiving services with referrals to a medical home in the past two months/# women receiving services.	By September 30, 2013, the percent of women receiving services with a referral to a medical home within the past two months will be greater after receiving home visiting services for two months than at the inception of services.	Web-based case management system	Two factors negatively affect the validity of this indicator: 1. With respect to services received before program inception, it relies on self report and 2. The data sources for the historical services and for services provided while the women are enrolled in the program are different.
	Track but do not report: Percent of mothers who visited a hospital emergency room for any reason in the past six months." **Calculation:** # non-pregnant women receiving services with an emergency room visit within the past six months/ # non-pregnant women receiving services	By September 30, 2013, a lower percentage of mothers receiving services will have visited the emergency room in the past six months after 12 months of receiving services than at the inception of services.	Florida Agency for Health Care Administration, perhaps through data they already supply to the Department of Health	This indicator is both valid and reliable. This indicator has face validity for the construct.

Benchmark Area 2: *Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Information provided or training of participants on prevention of child injuries	Percent of clients having received safety training or information on at least three of the following topics: safe sleeping, shaken baby syndrome, use of car seats, poisoning, lead exposure, faire safety, water safety, playground safety" **Calculation:** # families receiving safety information or training on at least three of the topics listed above/ # families receiving services	By September 30, 2013, the percent of families receiving safety training or information on three or more topics will be greater after 12 months of service than at the inception of service.	Web-based case management system	This indicator is compromised somewhat in both validity and reliability as it relies on the home visitor remembering to provide the safety information. When information is provided on each topic, it will be recorded in the system. This indicator has face validity for the construct.
Child injuries requiring medical treatment	Percent of children receiving services who received medical treatment for injuries." **Calculation:** # children receiving services who require medical care for injuries within the past three months/ # children receiving services	By September 30, 2013, for children who were at least two months of age at inception of service, the percent requiring medical care for injuries in the prior two months will be greater at the inception of services than after twelve months of receiving services.	Web-based case management system.	At the beginning of each visit, the home visitor will ask if the child has been to the doctor since the last visit and, if so, for sickness, injury, or well-child visit. This indicator is not as reliable as administrative data as it relies on parental report. Although we could use administrative data from emergency room visits, which would be more reliable, using parent report will be more valid as it will capture injuries treated in the doctor's office also.

Benchmark Area 2: *Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Reports of maltreatment for families receiving services	Percent of families receiving services who have received education or services designed to reduce the likelihood of child maltreatment in the past two months. **Calculation:** # families receiving services who have received education or services designed to reduce the likelihood of child maltreatment in the past two months/# families receiving services.	By September 30, 2013, the percent of families receiving services who have received education or services designed to reduce the likelihood of child maltreatment in the past two months will be greater after receiving home visiting services for three months than at the inception of services.	Web-based case management system	Two factors negatively affect the validity of this indicator: 1) With respect to services received before program inception, it relies on self report; and 2) The data sources for the historical services and for services provided while the women are enrolled in the program are different.

Benchmark Area 2: *Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Reports of maltreatment for families receiving services (cont.)	**Track but do not report:** Percent of children whose families are receiving services for whom there was a report of maltreatment to the Hotline within the previous six months (broken down by ages: 0-12 months, 13-36 months, and 37-84 months)" **Calculation:** For each age group above, # children receiving services with a report of maltreatment to the hotline within the past six months/ # children receiving services	By September 30, 2013, the percent of children whose families are receiving services for whom there was a report of maltreatment to the Hotline will be lower after 12 months of service than it was at the inception of service.	Department of Children and Families	In April of 2011, the Department of Children and Families modified its hotline procedures and policies, which will cause an anticipated jump in the number of reports of maltreatment. Given that programs will begin offering services in October 2011, this change will have minimal effects on indicators. This indicator has face validity for the construct.

Benchmark Area 2: *Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Substantiated or some indication of maltreatment for families receiving services	Percent of children whose families are receiving services with substantiated or some indication of maltreatment. (broken down by ages: 0-12 months, 13-36 months, and 37-84 months)" **Calculation:** For each age group above, # children receiving services with substantiated or some indication of maltreatment within the prior six months / # children receiving services	By September 2013, the percent of children whose families are receiving services with substantiated or some indication of maltreatment will be lower after 12 months of service than it was at the inception of service.	Department of Children and Families	For this and the next indicator we use both substantiated cases and some indication cases because Department of Children and Families staff indicate that using a combination of the two helps control for local differences in rates of reporting and in the propensity of local investigators to determine that maltreatment has occurred. This indicator has face validity for the construct.

Benchmark Area 2: *Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
First ever substantiated or some indication of maltreatment of children whose families are receiving services	Percent of children whose families are receiving services with first time ever substantiated or some indication of maltreatment (broken down by ages: 0-12 months, 13-36 months, and 37-84 months)." **Calculation:** For each age group above, # children receiving services with a first substantiated or some indication of maltreatment within the prior three months/ # children receiving services	By September 30, 2013, the percent of children whose families are receiving services with first time ever substantiated or some indication of maltreatment will be lower after 12 months of service than it was at the inception of service.	Department of Children and Families	This indicator has face validity for the construct.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Parent support for child's learning and development	Percent of families with children receiving services reporting that child is read to three or more times per week (for children over 6 months of age) or (for infants less than six months of age) that on a typical day the parent has played, talked, or sung with the infant for more than sixty minutes. " **Calculation – for children six months or older:** # families reporting that the child is read to three or more times per week/ # families receiving services **Calculation – for infants less than six months of age:** # families reporting that on a typical day the parent has played, talked, or sung with the infant for more than sixty minutes / # families receiving services	By September 30, 2013, a higher percentage of families receiving services for 12 months will report reading to their child three or more times per week or playing talking or singing to the infant for more than sixty minutes per day (depending on the child's age) than at the inception of services or when the child was two weeks old.	Web-based case management system based on data from responses to question 3 in the Baby FACES study assessment.	This question is one of several on the parental involvement scale of the IT- and EC- HOME, a well-validated tool. However, the question has been used successfully alone in a randomized controlled study of Early Head Start and is currently being used in the evaluation of the Baby FACES program. Reading to a child is one way that a parent shows support for a child's learning and development. This indicator has face validity for the construct. To improve validity, the same question will be used initially and at twelve months of service, regardless of the child's age at twelve months of service.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Parent knowledge of child development and of their child's developmental progress	Percent of mothers scoring average or better on the Knowledge of Infant Development Inventory (KIDI) seventeen-question scale." **Calculation:** # mothers scoring average or better on the KIDI/ # of mothers assessed on the KIDI	By September 30, 2013, the percent of mothers scoring average or higher on the KIDI after twelve months of receiving services will be greater than the percentage at the inception of services.	Web-based case management system	This is a new scale based on a much longer, well validated tool. The seventeen question scale itself is in the process of being normed and validated. The seventeen questions comprising this scale each address a different aspect of parental knowledge of child development and this has face validity. We are looking for a less time-consuming assessment of parent knowledge of child development.
Parent behaviors and parent-child relationships	Percent of families receiving services that have completes an assessment of parent behaviors and parent/child relationships in the past three months. **Calculation:** # families receiving services who have completed an assessment of parent behaviors and parent/child relationships in the past three months/# families receiving services.	By September 30, 2013, the percent of families receiving services who have completed an assessment of parent behaviors and parent/child relationships in the past three months will be greater after receiving home visiting services for three months than at the inception of service	Web-based case management system	Two factors negatively affect the validity of this indicator: 1. With respect to services received before program inception, it relies on self report and 2. The data sources for the historical services and for services provided while the women are enrolled in the program are different.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Parent behaviors and parent-child relationships (cont.)	**Track but do not report:** Percent of families scoring at or above average on the responsiveness to parents scale on the IT- or EC-HOME assessment." **Calculation:** # families with children 4 months of age or older scoring at or above average on the responsiveness to parents scale of the IT- or EC-HOME/ # families assessed on the IT- or EC-HOME	By September 30, 2013, a higher percentage of families will score at or above average on the responsiveness to parents scale on the HOME after twelve months of services when compared to scores at the initiation of services or at four months of age.	Web-based case management system based on data from the IT-HOME (for children from birth to three years of age) or the EC-HOME (for children 3-6 years of age).	IT- and EC-HOME are well validated tools. This scale is derived directly from observations of how the child responds to the parent and thus reflects the parent-child relationship directly and parent behaviors indirectly.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Parent emotional well-being or parenting stress	Percent of mothers receiving services responding "frequently" to two or more of three items on the Parenting Stress Index, Parent Distress Scale. **Calculation:** # mothers receiving services answering frequently to two or more of three Parenting Stress Index questions/ # mothers receiving services who were assessed on the index	By September 30, 2013, for women receiving services the percent of mothers responding "frequently" to two or more of three items on the Parenting Stress Index, Parent Distress Scale after twelve months of services will be lower than the percent at initiation of services or when their infant was three months of age.	Web-based case management system based on three items on the Parenting Stress Index, Parent Distress Scale.	The Parenting Stress Index, Parent Distress Scale is a well-validated instrument.
Child's communication, language, and emergent literacy	Percent of children completing the communications assessment of the ASQ in the past three months. **Calculation:** # of children receiving services who have been assessed on the communications scale of the ASQ in the past three months/# of children receiving services	By September 30, 2013, the percent of children receiving services who have been assessed on the communication scale of the ASQ in the past three months will be greater after receiving home visiting services for three months than at the inception of services.	Web-based case management system	Two factors negatively affect the validity of this indicator: 1) With respect to services received before program inception, it relies on self report; and 2) The data sources for the historical services and for services provided while the women are enrolled in the program are different.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Child's communication, language, and emergent literacy (cont.)	**Track but do not report:** Percent of children receiving services who score at or above age level in the communications area of the Ages and Stages Questionnaire (ASQ)." **Calculation:** # of children receiving services who score at or above age level in the communications area of the ASQ/ # children assessed in the communications area of the ASQ	By September 30, 2013, there will be an increase in the percentage of children receiving services at or above age level between the initial assessment (at initiation of services or as soon as the child is four months of age) and the one-year assessment on the communications scale of the ASQ.	Web-based case management system based on the ASQ administered by the home visitor at entry into the program or at age four months, whichever comes first, and after the family has received services for 12 months.	If services begin prenatally and the first assessment occurs when the baby reaches four months of age, there probably will not be a sufficient time lapse between the first and second assessment to see an improvement. Ages and Stages is a well established and validated tool that produces reliable results. This indicator has face validity for a child's communication skills.
Child's general cognitive skills	Percent of children completing the communications assessment of the ASQ in the past three months. **Calculation:** # of children receiving services who have been assessed on the communications scale of the ASQ in the past three months/# children receiving services.	By September 30, 2013, the percent of children receiving services who have been assessed on the communications scale of the ASQ in the past three months will be greater after receiving home visiting services for three months than at the inception of services.	Web-based case management system	Two factors negatively affect the validity of this indicator: 1) With respect to services received before program inception, it relies on self report; and 2) The data sources for the historical services and for services provided while the women are enrolled in the program are different.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Child's general cognitive skills (cont.)	**Repeat indicator - Track but do not report:** Percent of children receiving services who score at or above age level in the communications area of the Ages and Stages Questionnaire (ASQ)." **Calculation:** # of children receiving services who score at or above age level in the communications area of the ASQ/ # children assessed in the communications area of the ASQ	By September 30, 2013, there will be an increase in the percentage of children receiving services at or above age level between the initial assessment (at initiation of services or as soon as the child is four months of age) and the one-year assessment on the communications scale of the ASQ.	Web-based case management system based on the ASQ administered by the home visitor at entry into the program or at age four months, whichever comes first, and after the family has received services for 12 months.	If services begin prenatally and the first assessment occurs when the baby reaches four months of age, there probably will not be a sufficient time lapse between the first and second assessment to see an improvement. Ages and Stages is a well established and validated tool that produces reliable results. This indicator has face validity for a child's communication skills.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Child's positive approaches to learning, including attention	The percent of children scoring average or better on the exploration and early logic scale (for ages 0-3) or the initiative scale (for ages 3-6) of the Child Observation Record." **Calculation:** # of children receiving services who score average or better on the exploration and early logic or the initiative scale of the Child Observation Record/ # children assessed on the scale of the Child Observation Record	By September 30, 2013, there will be an increase in the percentage of children at or above age level between the initial assessment and the one-year assessment on the exploration and early logic scale of the Child Observation Record.	Web-based case management system	This is a well-validated tool. However, home visitors will have to be trained regarding how to conduct the appropriate observations to score the scale. Therefore reliability may be somewhat compromised due to inconsistent implementation.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Child's social behavior, emotion regulation, and emotional well-being	Percent of children completing the personal social assessment of the ASQ in the past three months. **Calculation:** # of children receiving services who have been assessed on the personal-social scale of the ASQ in the past three months/# children receiving services	By September 30, 2013, the percent of children receiving services who have been assessed on the personal social scale of the ASQ in the past three months will be greater after receiving home visiting services for three months then at the inception of services.	Web-based management system	Two factors negatively affect the validity of this indicator: 1. With respect to services received before program inception, it relies on self report and 2. The data sources for the historical services and for services provided while the women are enrolled in the program are different.
	Track but do not report: Percent of children receiving services who score at or above age level in the personal-social area of the Ages and Stages Questionnaire (ASQ)." **Calculation: #** of children receiving services who score at or above age level in the Personal-social area of the Ages and Stages Questionnaire (ASQ)/ # of children assessed in the area	By September 30, 2013, there will be an increase in the percentage of children at or above age level between the initial assessment (at initiation of services or as soon as the child is four months of age) and the one-year assessment.	Web-based case management system based on the ASQ administered by the home visitor at entry into the program or at age four months, whichever comes first, and after the family has received services for 12 months.	If services begin prenatally and the first assessment occurs when the baby reaches four months of age, there probably will not be a sufficient time lapse between the first and second assessment to expect an improvement. This indicator has face validity for the construct.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Child's physical health and development	**Repeat indicator from well-child visits:** Percent of children being served with a well baby check-up at least twice a year for year one and annually thereafter.[>] **Calculation:** # children receiving services who receive well baby checkups/# children receiving services	By September 30, 2013, the percent of children receiving services that have had a well-child check up in the past two months will be greater after two months of receiving home visiting services than at the inception of services.	Web-based case management system based on PRAMS question 66.[a]	At the beginning of each visit, the home visitor will ask if the child has been to the doctor since the last visit and, if so, for sickness, accident, or well-child visit. This indicator is not as reliable as administrative data as it relies on parental report but asking it frequently diminishes concern about parents' recall accuracy. Well-baby check-up are a proxy for child physical health and development. Good quality well-baby check up will identify developmental and health problems early and refer the child to preventive or early intervention services. Two factors negatively affect the validity of this indicator: 1. With respect to services received before program inception, it relies on self report and 2. The data sources for the historical services and for services provided while the women are enrolled in the program are different.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Child's physical health and development (cont.)	**Track but do not report:** Percent of children receiving services who score at or above age level on either the gross motor or fine motor scales of the ASQ." **Calculation: #** of children receiving services who score at or above age level in the gross motor or fine motor scales of the Ages and Stages Questionnaire (ASQ)/ # of children assessed in the scales	For children born before service inception, by September 30, 2013, the percent of children receiving services who score at or above age level on the gross motor or fine motor scales of the ASQ will be greater after 12 months service than at service initiation (at initiation of services or as soon as the child is four months of age).	Web-based case management system based on the ASQ administered by the home visitor at entry into the program or at age four months, whichever comes first, and after the family has received services for 12 months.	If services begin prenatally and the first assessment occurs when the baby reaches four months of age, there probably will not be a sufficient time lapse between the first and second assessment to expect an improvement. Children in poor health or who are experiencing developmental delays are more likely to perform poorly on this scale.

Benchmark Area 4: *Crime or Domestic Violence*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Screening for domestic violence	Percent of families with reported incidence of domestic violence in the past 6 months." **OR** Percent of mothers who respond affirmatively to PRAMS question 44. **Calculation:** # families receiving services with reported domestic violence within the past six months/# families receiving services	By September 30, 2013, the percent of mothers experiencing domestic violence after receiving services for 12 months will be less than the percent experiencing it at service initiation.	Florida Department of Law Enforcement (FDLE) or Web-based case management system based on a modified version PRAMS question 44.[a]	If identified data cannot be obtained from FDLE, self report data will be collected from the clients. This indicator relies on the mothers' self report detracting somewhat from validity; the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. One cannot measure improvements in domestic violence without measuring the level of domestic violence.

Benchmark Area 4: *Crime or Domestic Violence*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services	Percent of families identified with past domestic violence referred to relevant domestic violence services.[#] **Calculation:** # families with reported domestic violence who are referred for relevant domestic violence services/ # families receiving services with reported domestic violence	By September 30, 2013, the percent of women receiving services who have experienced domestic violence who are referred for domestic violence services will be greater after 12 months of services than at inception of services.	Web-based case management system	This measure is both reliable and valid as referrals and their utilization will be captured in the web-based automated system. One cannot expect to see improvements in this outcome without appropriate referrals.
Of families identified for the presence of domestic violence, the percent of families for which a safety plan was completed	Percent of families identified with past domestic violence with a completed safety plan.# Calculation: Of families with verified domestic violence # with a completed safety plan/ # families receiving services with verified domestic violence	By September 30, 2013, the percent of women receiving services who have experienced domestic violence who have a completed safety plan after having received services for 2 years will be greater than the percent with completed safety plans after receiving services for one year.	Web-based case management system	This measure is both reliable and valid as safety plans will be captured in the web-based automated system. A safety plan is one aspect of attempting to reduce the incidence of domestic violence.

Benchmark Area 5: *Family Economic Self-Sufficiency*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Household income and benefits	Percent of families receiving services with household income at or below 100% of poverty who are receiving public assistance such as TANF, food stamps, WIC, housing subsidies." **Calculation:** # Families with household income at or below 100% of poverty who are receiving some form of public assistance (see above)/ # Families with household income below 100% of poverty	By September 30, 2013, a higher percentage of families receiving services that are at or below 100% of poverty will be receiving public assistance after receiving home visiting services for twelve months than at the inception of services.	Web-based case management system	Where possible, we will populate the system with administrative data, but we may have to rely on mothers' self report regarding receipt of public assistance.
	Track but do not report: Total household income for the previous calendar year.^ **Calculation:** The answer to PRAMS question 81 after 12 months of service minus the answer at inception of services	By September 30, 2013, there will be a positive difference between household income at the inception of services and income after having received services for 12 months for families receiving service.	Web-based case management system based on PRAMS question 81[a].	This indicator relies on the mothers' self report, detracting somewhat from validity; the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. This indicator has face validity for the construct.

Benchmark Area 5: *Family Economic Self-Sufficiency*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Employment of household adults	Percent of families receiving services with at least one adult member of the household employed full time." **Calculation:** # of families receiving services with at least one adult family member employed full time/ # families receiving services	By September 30, 2013, a greater percentage of families receiving services will have at least one adult household member employed full time after receiving services for 12 month than at the inception of services.	Web-based case management system	This indicator is compromised in both validity and reliability as it relies on the home visitor remembering to ask for the information at pre-specified times in a free-form question. This indicator has face validity for the construct.

Benchmark Area 5: *Family Economic Self-Sufficiency*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Education status of household adults	**Track but do not report:** Percent of mothers receiving services with a high school diploma or GED." **Calculation:** # mothers receiving services with a high school diploma or GED/ # mothers receiving services Percent of mothers who have completed some post-secondary education (including certifications and AA degrees)." **Calculation:** # mothers receiving services who have completed some post-secondary education / # mothers receiving services Percent of mothers with a bachelors degree or higher" **Calculation:** # mothers receiving services with a bachelor's degree or higher/ # mothers receiving services	By September 30, 2013, there will be an increase in the percentage of mothers receiving services who have reached an educational milestone (GED, Associates Degree, certification, Bachelor's degree) from the inception to services to the end of the twelfth month of services.	Web-based case management system	This indicator is compromised in both validity and reliability as it relies on the home visitor remembering to ask for the information at pre-specified times in a free-form question. This indicator has face validity for the construct.

Benchmark Area 5: *Family Economic Self-Sufficiency*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
	Percent of mothers currently enrolled in an education program." **Calculation:** # mothers receiving services currently enrolled in educational activities/ # mothers receiving services	By September 30, 2013, there will be an increase in the percentage of mothers currently enrolled in an education program from the inception to services to the end of the twelfth month of services.	Web-based case management system based on a modified version of PRAMS question C1[b]	This indicator is compromised in both validity and reliability as it relies on the mother's self-report. This indicator addresses potential for future educational status rather than present educational status.
Health insurance status	Percent of children receiving services with each type of health insurance.[=] **Calculation:** # children receiving services with each type of health insurance/ #children receiving services	By September 30, 2013, the percent of children with health insurance after 3 months of receiving services will be greater than the percent of children with health insurance at the inception of services.	Web-based case management system based on a modified version of PRAMS question 2	Although this indicator relies on the mothers' self report detracting somewhat from validity, the PRAMS questionnaire is used extensively and, therefore, has a high degree of reliability and validity. This indicator has face validity for the construct.

Benchmark Area 5: *Family Economic Self-Sufficiency*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Health insurance status (cont)	**Track but do not report:** Percent of mothers with health insurance, by type of insurance[=] **Calculation 1 – non-pregnant:** # non-pregnant mothers receiving services with each type of health insurance/ # non-pregnant mothers receiving services **Calculation 2 -- pregnant:** # pregnant mothers receiving services with each type of health insurance/ # pregnant mothers receiving services	By September 30, 2013, the percent of mothers with health insurance after 12 months of receiving services will be greater than the percent of mothers with health insurance at the inception of services. Separately calculated for pregnant and non-pregnant mothers.	Web-based case management system based on a modified version of PRAMS question 2	Although this indicator relies on the mothers' self report detracting somewhat from validity, the PRAMS questionnaire is used extensively and therefore, has a high degree of reliability and validity. This indicator has face validity for the construct.

Benchmark Area 6: *Coordination and Referrals for Other Community Resources and Supports*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Families identified for necessary services	Percent of families with a family services plan." **Calculation:** # of families receiving services with a family services plan/# families receiving services	By September 30, 2013, the percent of families with family services plans will higher after twelve months of services than at the inception of services.	Web-based case management system	This measure is both reliable and valid in that family services plans will be recorded automatically in the web-based case management system. A family services plan is one of the first steps in identifying a family's needs.
Families that require services and receive a referral to available community resources	Percent of families who received referrals appropriate to the families needs." **Calculation:** # Families with identified needs who received at least one referral appropriate to one need within one months of need identification/ # families with identified needs	By September 30, 2013, the percent of families receiving appropriate referrals within one month of need identification will be greater after 12 months of service than at service initiation.	Web-based case management system	This measure is both reliable and valid as referrals and their utilization will be captured in the web-based automated system. The only reliability and validity concern is that referrals must be recorded in the system by home visitors. This indicator has face validity for the construct.

Benchmark Area 6: *Coordination and Referrals for Other Community Resources and Supports*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Number of completed referrals	Percent of families with at least one referral for which referred services were received" **Calculation:** # of families receiving services with referrals for whom at least one referral service was received within 3 months of need identification/ # families receiving services with referrals	By September 30, 2013, the percent of families receiving appropriate referrals within three months of need identification will be greater after 12 months of service than at service initiation.	Web-based case management system	This measure is both reliable and valid as referrals and their utilization will be captured in the web-based automated system. The only reliability and validity concern is that referrals must be recorded in the system by home visitors. This indicator has face validity for the construct.
	Track but do not report: Percent of families with referrals for which at least 60% of referred services were received." **Calculation:** # of families receiving services with referrals for whom at least 60% of referral services were received within 12 months of need identification/ # families receiving services with referrals	By September 30, 2013, the percent of families receiving 60% appropriate referrals will be greater after 12 months of service than after three months of receiving services.	Web-based case management system	This measure is both reliable and valid as referrals and their utilization will be captured in the web-based automated system. The only reliability and validity concern is that referrals must be recorded in the system by home visitors. This indicator has face validity for the construct.

Benchmark Area 6: *Coordination and Referrals for Other Community Resources and Supports*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Number of completed referrals (cont.)	**Track but do not report:** Percent of families with fewer identified needs after receiving services for 12 months." **Calculation:** # families with needs at service inception who had fewer needs after 12 months of services (calculated by subtracting the number of needs at 12 months from the number of needs at service inception)/ # families with needs at service inception	By September 30, 2013, on average, families receiving services will have fewer needs after 12 months of receiving services than they did at the inception of services.	Web-based case management system	This measure is both reliable and valid as each family's needs can be captured and counted in the web-based automated system at any point in time. This indicator is indirectly associated with the construct but serves as a broader measure of whether appropriate services are being provided to client families whether through referrals or directly from the home visitor.
MOUs	Number of formal agreements with community providers.[#] **Calculation:** Count of agreements attached to quarterly reports	By September 30, 2013, the number of MOUs with community providers will increase from October 2011 levels.	Quarterly reports from communities	This measure is reliable and valid as communities will have to attach copies of MOUs to their quarterly reports. This indicator has face validity for the construct.

Benchmark Area 6: *Coordination and Referrals for Other Community Resources and Supports*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Information sharing	Number of agencies with which the home visitor provider has a clear point of contact.^ **Calculation:** Count of agencies listed in quarterly reports	By September 30, 2013, the number of agencies with which the home visitor provider has a clear point of contact will increase from October 2011 levels.	Quarterly reports from community implementers	This indicator's validity is compromised somewhat as it relies on community self-report. The self-report, however, will be validated through annual on-site monitoring. This indicator has face validity for the construct.
	Track but do not report: Percent of community implementers that have held at least two inter-organizational meetings per year. **Calculation:** # of communities implementing MIECHV who held at least two inter-organizational meetings in a year/# communities implementing MIECHV	By September 30, 2013, the percent of community implementers with at least two meetings per year attended by other community agencies will increase from 2011 levels.	Quarterly reports from communities	This measure is reliable and valid as communities will have to attach meeting summaries. This indicator relies on the assumption that valuable information is exchanged at such meetings.

Key to symbols used:

*Indicator will be measured once during each pregnancy

+Indicator will be measured once at the end of each pregnancy

^Indicator will be assessed quarterly

>Indicator will be assessed annually for primary child being served.

"Indicator will be measured at inception of services and then annually thereafter.

#Indicator will be assessed annually

[a] Question is derived from the Florida Pregnancy Risk Assessment Monitoring System (PRAMS) Phase VI used in 2009-2013

[b] Question is derived from PRAMS Phase 6 Standard Questions November 25, 2008

MEASURING OUTCOMES USING COMPARISON GROUPS AND EXPECTED VALUES

Besides measuring constructs for benchmark domains, Florida will extend the analysis of program outcomes when administrative data are available. For some benchmark domains and constructs, administrative data can be obtained for both women receiving program services and for a matched comparison group. The matched comparison group will be derived from birth records; comparison group members will be identified using matches on age, education, census tract, race, and ethnicity with women receiving services. The matched comparison group will be established at birth and will endure even if the family receiving services relocates to a different census tract. Some of the administrative data sources will not provide identified data —notably the Department of Education -- for either participating women or for a comparison group. However, they will provide aggregate data for both.

This analysis is being conducted to test the feasibility of using a more powerful measure of the success of Florida's MIECHV Program. The reporting of benchmarks as required by HRSA is a good first step to measuring success but ignores the possibility that improvements over time might have occurred without any intervention. Comparing system participants to similar members of their own communities who did not receive services is a more robust test of program success and will allow us to track outcomes longitudinally even after the family has completed the program.

In addition, Florida proposes to measure additional constructs for community collaboration. We plan to use an annual client satisfaction survey to obtain client's perceptions of the degree of collaboration encouraged by the program and CDC's PARTNERS tool to survey key program participants and partners to obtain their perceptions of the degree of collaboration.

Table 5.2: Measuring Program Success using Companion Group, Expected Values, and Survey Instruments

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Birth outcomes	Percent of births prior to 37 weeks gestation. **Calculation for women receiving services:** of women who began receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant the number who give birth prior to 37 weeks gestation / # women who began receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant **Calculation for matched comparison:** the # of women in the comparison group who give birth prior to 37 weeks gestation / # women in the comparison group	By September 30, 2013, a higher percentage of women who begin receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant will give birth at or after 37 weeks gestation when compared with infants born to women in the matched comparison group.	Vital statistics obstetrical/clinical estimate of gestational age	For this indicator, we can compare women receiving services with a matched comparison group. This indicator has face validity for the construct.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Birth outcomes (cont.)	Percent of births that are low birth weight. **Calculation for women receiving services:** of women who began receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant the number giving birth to low birth weight infants (2500 grams)/ # women who began receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant **Calculation for women in the comparison group:** the # of women in the comparison group who give birth to low birth weight infants / # women in the comparison group	By September 30, 2013, a higher percentage of infants born to women who begin receiving services before the end of the second month of pregnancy or who were receiving services at the time they became pregnant will be of normal birth weight when compared with infants born to women in the matched comparison group.	Vital statistics	For this indicator, we can compare women receiving services with a matched comparison group. This indicator has face validity for the construct.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Adequacy of the number of prenatal visits (modified Kotelchuck Index)	Percent of pregnant women with an adequate modified Kotelchuck Index. **Calculation for women receiving services:** # pregnant women receiving services with an adequate number of prenatal visits during the months services were provided/ # pregnant women who began receiving services during pregnancy **Calculation for matched comparison group:** # women in the comparison group with an adequate number of prenatal visits/ # women in the comparison group pregnant in the given interval	By September 30, 2013, the percent of women who began receiving services during the pregnancy with an adequate modified Kotelchuck Index during the months services were provided will be higher than for the matched comparison group.	Vital statistics	For this indicator, we can compare women receiving services with a matched comparison group The indicator is a direct measure of the construct.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Ambulatory Care Sensitive (ASC) Hospitalization rates (children ages 0-4)	Percent of children ages 0-4 with ASC hospitalizations. **Calculation for families receiving services:** # children receiving services with ASC hospitalizations/ # children receiving services **Calculation for families in the matched comparison group:** # of children in the matched comparison group with ASC hospitalizations / # children in the matched comparison group	By September 30, 2013, the percent of children ages 0-4 receiving services with ASC hospitalizations will be lower than for the matched comparison group.	Hospital discharge records from Florida's Agency for Health care Administration, possibly supplied through the Florida Department of Health	For this indicator, we can compare children receiving services with a matched comparison group. There may be more challenges matching children across data sets because there are fewer identifiers for children than for adults. ICDN codes for ACS for children 0-4: The standard list of ASCH conditions as defined by the Agency for Healthcare Research and Quality (excluding adult conditions and adding: acute respiratory tract infections {*ICD-9-CM* codes 464, 466}), 4 pneumococcal meningitis (*ICD-9-CM* code 320.1), streptococcal meningitis (*ICD-9-CM* code 320.2), and septicemia due to *Haemophilus influenza* (*ICD-9-CM* code 038.41).

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Inter-pregnancy intervals	For women with a pregnancy while receiving services (or while a member of the comparison group), the percent of births for which the interpregnancy interval was less than 18 months. **Calculation for families receiving services:** # women who became pregnant while receiving services who have an interpregnancy interval of less than 18 months/ # women receiving services **Calculation for families in the matched comparison group:** # women in matched comparison group who became pregnant who have an interpregnancy interval of less than 18 months/ # women in the comparison group	By September 30, 2013, the percent of women receiving services who become pregnant with an interpregnancy interval of less than 18 months will be lower than the comparison group.	Vital statistics	For this indicator, we can compare women receiving services with a matched comparison group. However, there are not expected to be a large number of women becoming pregnant while receiving services.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Child visits to the emergency room (reasons other than injuries)	Percent of children 0-4 with emergency room visits that are not injury-related. **Calculation for families receiving services:** # children 0-4 receiving services with non-injury related emergency room visits/ # children receiving services **Calculation for families in the matched comparison group:** # children 0-4 in the comparison group with non-injury related emergency room visits/ # children 0-4 in the comparison group	By September 30, 2013, a lower percentage of children receiving services will have non-injury-related emergency room visits than children in the comparison group.	Florida Agency for Health Care Administration, perhaps through data they already supply to the Department of Health	We will be able to compare emergency room data for children receiving services with similar data for children in the comparison group This indicator is a proxy for determining if children have a medical home. If a child has a medical home, he/she will have fewer visits to the emergency room for reasons other than injury.

Benchmark Area 1: *Improved Maternal and Newborn Health*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
	Average annual number of emergency room visits for children 0-4 years of age. **Calculation for families receiving services:** Total number of non-injury related emergency room visits for children 0-4 receiving services during a 12-month period/number of children receiving services **Calculation for families in the matched comparison group:** Total number of non-injury related emergency room visits for children 0-4 in the comparison group during a 12-month period/number of children in comparison group	By September 30, 2013, children receiving services will have fewer non-injury-related emergency room visits than children in the comparison group.	Florida Agency for Health Care Administration, perhaps through data they already supply to the Department of Health	We will be able to compare emergency room data for children receiving services with similar data for children in the comparison group. This indicator is a proxy for determining if children have a medical home. If a child has a medical home, he/she will have fewer visits to the emergency room for reasons other than injury.

Benchmark Area 2: *Child Injuries, Child Abuse, Neglect, or Maltreatment, and Reduction of Emergency Department Visits*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Child visits to the emergency department for non-fatal injuries	Percent of children with emergency room visits for non-fatal injuries. **Calculation for families receiving services:** # children receiving services with non-fatal injury emergency room visits/ # children receiving services **Calculation for families in the matched comparison group:** # children in the comparison group with non-injury related emergency room visits/ # children in the comparison group	By September 30, 2013, the percent of children receiving services who visit the emergency room for non-fatal injuries will be lower than for children in the comparison group.	Florida Agency for Health Care Administration, perhaps through data already supplied to the Department of Health	We will be able to compare emergency room data for children receiving services with similar data for children in the comparison group. This indicator has face validity.

Benchmark Area 2: *Child Injuries, Child Abuse, Neglect, or Maltreatment, and Reduction of Emergency Department Visits*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Hospitalization rate (per 1000 children) for non-fatal injuries (children ages 1-4)	Rate of hospitalization for non-fatal injuries (children 1-4). **Calculation for families receiving services:** # children 1-4 receiving services with hospitalizations for non-fatal injuries/# children 0-4 receiving services **Calculation for families in the matched comparison group:** # children 1-4 in the comparison group with hospitalizations for non-fatal injuries/ # children in the comparison group	By September 30, 2013, the percent of children receiving services who are hospitalized for non-fatal injuries will be lower than for children in the comparison group.	Hospital discharge records from Florida's Agency for Health care Administration, possibly supplied through the Florida Department of Health.	We will be able to compare hospitalization data for children receiving services with similar data for children in the comparison group. This indicator has face validity.

Benchmark Area 2: *Child Injuries, Child Abuse, Neglect, or Maltreatment, and Reduction of Emergency Department Visits*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Substantiated or some indication of maltreatment (families receiving services)	Unduplicated verified victims plus unduplicated non-substantiated (some indication) ages 1-4 years as % of 1-4 population. **Calculation for families receiving services:** # children 1-4 receiving services with verified or substantiated maltreatment/ # children 1-4 receiving services **Calculation for families in the matched comparison group:** # children 1-4 in the comparison group with verified or substantiated maltreatment/ # children 1-4 in the comparison group	By September 30, 2013, the percent of children with verified or non-substantiated maltreatment will be lower for children receiving services than for matched comparison children.	Department of Children and Families	For this indicator, we can compare children receiving services with a matched comparison group. This indicator has face validity.

Benchmark Area 2: *Child Injuries, Child Abuse, Neglect, or Maltreatment, and Reduction of Emergency Department Visits*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Substantiated or some indication of maltreatment (families receiving services) (cont.)	Unduplicated verified victims plus unduplicated non-substantiated (some indication) ages 0-1 years as % of 0-1 population. **Calculation for families receiving services:** # children 0-1 receiving services with verified or substantiated maltreatment/ # children 0-1 receiving services **Calculation for families in the matched comparison group:** # children 0-1 in the comparison group with verified or substantiated maltreatment/ # children 0-1 in the comparison group	By September 30, 2013, the percent of infants with verified or non-substantiated maltreatment will be lower for infants receiving services than for matched comparison infants.	Department of Children and Families	For this indicator, we can compare children receiving services with a matched comparison group. This indicator has face validity.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Enrollment in preschool	Percent of children enrolled in preschool. **Calculation for families receiving services:** # pre-kindergarten children receiving services who are enrolled in Early Head Start or another state certified preschool/ # children receiving services **Calculation for children in the census tract:** # pre-kindergarten children in the census tract who are enrolled in Early Head Start or another state certified preschool/ # children in the census tract	By September 30, 2013, the percent of children receiving services who are enrolled in Early Head Start or in other state certified preschools will be higher than the percentage of children in the birth census tract who are similarly enrolled.	Web-based case management system and Department of Education.	To make a valid comparison, all certified preschools in a census tract will have to be identified. This indicator has face validity.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Kindergarten promotion rates	Percent of children being promoted to first grade from kindergarten. **Calculation for families receiving services:** We will request the Department of Education to calculate the percentage for children receiving services **Calculation for similar families:** We will request the Department of Education to calculate the percentage for children in the comparison group	By September 30, 2013, the percent of children being promoted to first grade will be higher for children receiving services than for matched comparison children.	Department of Education	Given previous experience with the Department of Education, it is unlikely that we will be able to obtain identified data for program participants and a matched comparison group. However, we will request aggregated data for program participants and separate aggregated data for matched comparisons in their dataset. This indicator has face validity.

Benchmark Area 3: *Improvements in School Readiness and Achievement*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
First grade promotion rates	Percent of children being promoted from first to second grade. **Calculation for families receiving services:** We will request the Department of Education to calculate the percentage for children receiving services **Calculation for similar families:** We will request the Department of Education to calculate the percentage for children in the comparison group	By September 30, 2013, the percent of children being promoted from first to second grade will be higher for children receiving services than for matched comparison children.	Department of Education	Given previous experience with the Department of Education, it is unlikely that we will be able to obtain identified data for program participants and a matched comparison group. However, we will request aggregated data for program participants and separate aggregated data for matched comparisons in their dataset. This indicator has face validity.

Benchmark Area 4: *Domestic Violence*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Domestic Violence rates	Percent of women reporting domestic violence. **Calculation for families receiving services:** # women receiving services who reply "yes" to PRAMS question 44/ # women receiving services **Calculation for families in the matched comparison group:** % women responding yes to PRAMS question 44	By September 30, 2013, the percent of women reporting being victims of domestic violence will be lower for women receiving services than for other women with similar demographics.	Web-based case management system based on responses to a modified version of PRAMS question 44 and results based on responses to PRAMS question 44.	Domestic violence rates can be compared between the women receiving services and women in the comparison group. If identified domestic violence data cannot be obtained, domestic violence rates for program participants can be compared to domestic violence rates in that same census tract. This indicator has face validity.

Benchmark Area 5: *Family Economic Self-Sufficiency*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Household income	Average percentile of household income related to state household income. **Calculation:** The percentile of the household income with respect to the entire distribution of household incomes for Florida households at the time the measurement is made	By September 30, 2013, the average percentile of household income for families receiving services will increase from the inception of services to 12 months after services have begun.	Based on PRAMS question 81.	This indicator is based on self report; the PRAMS questionnaire is well validated.

Benchmark Area 6: *Coordination and Referrals for other community resources*				
Construct	**Indicator**	**Objective**	**Source**	**Caveats/Reliability/Validity**
Client satisfaction	Percent of clients satisfied with program services.	By September 30, 2013, the percent of program clients satisfied or very satisfied with the program will increase from September 30, 2012, levels.	Annual customer satisfaction survey	Items for this survey will be combined from several validated instruments.
Evaluation of community collaboration	The extent of community collaboration as evaluated by community partners' and clients' perception of the level of collaboration	By September 30, 2013, the extent of community collaboration measured using the PARTNERS tool for community partners and a customer satisfaction survey will be greater than in March 2012.	PARTNERS: Annual survey of key community participants and a to-be-developed client satisfaction survey	The PARTNERS tool has been well validated and is currently being used to assess collaboration in a variety of settings.

MEASURING THE DEVELOPMENT AND IMPLEMENTATION OF FLORIDA'S MIECHV PROGRAM

State Activities and Processes

Based on meeting summaries and other documentation, a chronological description of implementation efforts on the state level will provide a basis for evaluating Florida's efforts to achieve statewide goals and objectives. Also, the state's implementation efforts will be evaluated in comparison to the proposed timeline included in the updated state plan.

In addition to describing the state's activities related to achievement of each goal, by December 31, 2011, baseline values will be collected for each of the statewide objectives. Annual values will be obtained each December to determine if Florida is experiencing improvement on statewide objectives.

The evaluation will include answers to the following questions:

1. How is agency staff interacting with communities and national offices to solve problems and ensure the success of Florida's MIECHV Program?
2. What systems does the state have in place for managing the program and how are they being implemented?
3. What does the collaboration among state agencies and other statewide organizations look like? Are those collaborations facilitating program implementation?

Community Activities and Processes

Two major data sources will be used to describe and evaluate community implementation activities: quarterly reports and annual site visits. Beginning with the quarter ending September 30, 2011, local agencies implementing MIECHV projects will be required to submit structured quarterly reports about their implementation activities in the previous quarter. So that similar information is collected from all implementing agencies, unique templates for reports will be created by the evaluation team. Templates will vary from quarter to quarter, depending on the expected stage of development of local programs. Beginning with the quarter ending December 31, 2011, the first quarter during which it is expected that local programs will be providing services for families, selected data from the Web-based case management system will be analyzed to evaluate how services are being provided and to whom.

From these two sources of data many process variables can be evaluated including but not limited to:

- What kinds of services are being provided?
- What is the attrition rate?
- How is coordination of care actually working?
- What are the demographic characteristics of the population being served?
- How close to capacity is the local program operating?
- Is the program on track for national accreditation?

In addition, agency staff and the evaluation team will conduct structured annual site visits with each implementing agency to ensure that community implementers are meeting their contractual obligations, validate the content of quarterly reports, assess actions taken related to technical assistance that has been provided, determine the degree to which program data is being used locally for CQI, and ascertain how state level management might be improved to better meet the needs of program implementers.

TIMELINE FOR THE EVALUATION PLAN

For the first phase of evaluation, July 1, 2011, through June 30, 2012, evaluation activities will be closely tied to model implementation. By the end of this period, Florida will have an evaluation system in place that will guide future process and outcome evaluations. Florida will have mechanisms in place to collect and analyze services data, administrative data for program participants as well as for a matched comparison group, and both statewide and local process data. The evaluation system will be continuously evaluated itself so that modifications can be made to more effectively evaluate Florida's MIECHV program.

Activity	Month													
	6/11	7/11	8/11	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12
Developing infrastructure														
Select the web-based case management system														
Finalize decision s about all assessment tools														
Make decision about initial management reports and tools for the web-based system														
Case management system developed and tested														
Procure data use agreements for all needed administrative data														
Seek and obtain all needed IRB approval for collection of identified data														

Activity	Month													
	6/11	7/11	8/11	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12
Measuring benchmarks and other federally required reporting														
Ensure that all needed data are collected by web-based system and/or Comprehensive birth registry														
Create demonstration of benchmark data														
Include available benchmark data in the end of year report														
Implementation and Service Integration Evaluation														
Work with agency staff to determine contents of quarterly reports														
Develop template for quarterly report from community														
Analyze data and produce quarterly report														
Include implementation and service integration analysis in end of year report														
Evaluation of Community Collaboration														
Finalize decision about all the ways community collaboration will be measured														
Explore PARTNERS														
If necessary, customize PARTNERS tool to meet our needs														

Activity	Month													
	6/11	7/11	8/11	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12
First administration of PARTNERS in implementing communities														
With agency staff plan fist site visit to implementing communities														
Conduct first site visits														
Analyze data from site visits														
Analyzed data from PARTNERS														
Develop client survey to be administered annually														
Include community collaboration analysis in the end of year report														
Comparison of participant outcomes with comparison group or expected values														
Design the Comprehensive Birth Registry														
Produce a mock report for all relevant births from 10/1/11 through 12/31/11														
Include comparison data in the end of year report														
Using information and data to improve program management														
Work with agency staff to finalize what needs to be monitored and recorded														
Ensure mechanism is in														

Activity	Month													
	6/11	7/11	8/11	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12
place to collect meaningful data														
Use information from first round implementation to improve second round community recruitment														
Develop baseline levels for statewide objectives														
Include statewide information in year-end report with appropriate recommendations for program improvement														

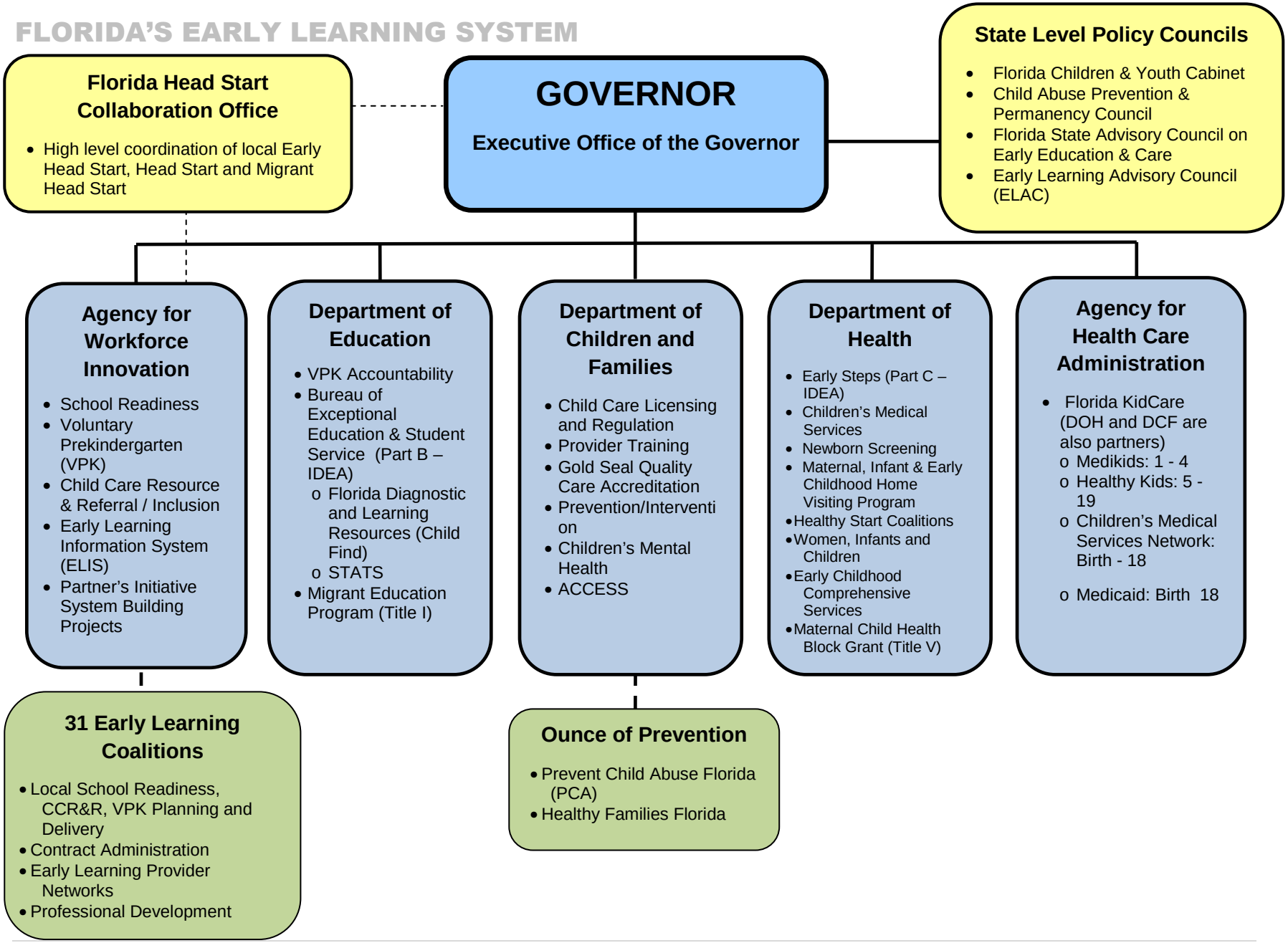
SECTION 6: PLAN FOR ADMINISTRATION OF THE STATE HOME VISITING PROGRAM

FLORIDA'S INFRASTRUCTURE

Florida has multiple agencies and groups that advocate and provide services for children and their families. An environmental scan to identify organizations that provide support services and advocacy for young children was conducted as part of the Florida Early Childhood Comprehensive Systems (ECCS) Grant. The complete environmental scan can be found in Appendix 9. The agencies described below make up the Florida's Early Childhood System of Care.

In 2010, Florida received funding through the American Recovery and Reinvestment Act to create an advisory council as mandated in the Head Start Reauthorization Act. The State Advisory Council on Early Childhood Education and Care will lead the development of a high quality, comprehensive system of early childhood education and care that ensures statewide coordination and collaboration among the wide variety of early childhood programs and services in the state. Among the Council's required activities is the development of a unified data collection system for early childhood development programs and services. The Council also plans to develop a statewide system of professional development for providers of early childhood services. The State Advisory Council will act as an advisory body to the ECCS Multi-Agency Team and the Florida Children and Youth Cabinet. The diagram below illustrates the Council's portrayal of Florida's Early Learning System of state agencies and programs as well as state level policy councils. It is within this system that the MIECHV Program will interact and collaborate. Appropriate professionals from these agencies and councils will be invited to serve on the MIECHV Task Force which is described later.

FLORIDA'S EARLY LEARNING SYSTEM



The Florida Children and Youth Cabinet

The Florida Children and Youth Cabinet is charged with the responsibility to promote collaboration, increased efficiency, information sharing, and improved service delivery between and within state governmental organizations that provide services for children, youth and their families (Florida Statutes 402.56). The Children and Youth Cabinet is chaired by the Lieutenant Governor and includes members of the Florida Legislature, agency heads from all organizations that serve children, and representatives from children and youth advocacy groups. The Cabinet's mission is to ensure that Florida's public policy relating to children and youth promotes interdepartmental collaboration and program implementation so that services are planned, managed, and delivered in a holistic and integrated manner. To that end, the Cabinet has launched a multi-agency data sharing initiative designed to allow agencies that serve Florida's children to better communicate, collaborate and improve service delivery. The Children and Youth Cabinet Information Sharing System (CYCISS) will provide state agencies with a tool to better facilitate provision of services in a timely manner, exchange and share data quickly and cost effectively, and identify and eliminate service overlaps and gaps between agencies. In addition to designing the state MIECHV plan in collaboration with the required agencies, the workgroup also considered the four ambitious goals of the Florida Children's Cabinet, shown below, and the indicators they use to measure program success, which appear under each goal:

1. *Every Florida child is healthy*
    - Mothers beginning prenatal care in the first trimester
    - Children with health insurance
    - Children with a medical home
2. *Every Florida child is ready to learn*
    - Births to women with fewer than 12 years of education
    - Children who are read to by their parents or relative caregivers
    - Children whose kindergarten entry assessment scores show they are ready for school
    - Early childhood staff with bachelor's degrees
3. *Every Florida child lives in a stable and nurturing family*
    - Children in poverty
    - Children who are maltreated
    - Teen births
4. *Every Florida child lives in a safe and supportive community*
    - Domestic violence
    - Homeless children
    - Children in supportive neighborhoods

Therefore, the goals and objectives of the MIECHV Program are aligned with the goals of the Children and Youth Cabinet. Florida has numerous other interagency groups that focus on services for young children and their families which are linked to the Children and Youth Cabinet.

Formally Established Interagency Groups

Early Childhood Multi-Agency Team

As Florida implements its statewide home visiting program, it will be imbedded in a system of care that encompasses all efforts to promote maternal and child well-being, regardless of the funding source. Therefore, the development of this state plan drew on the 2009 needs assessment developed by Florida's ECCS, funded by HRSA. The ECCS' vision is to ensure that all Florida children are healthy, ready to learn, and live in safe, nurturing families and communities, a philosophy consistent with the benchmark domains of the federal home visiting program. The ECCS's new focus on the development of a system of care mirrors that of Florida's evidence-based home visiting program, which will also be embodied in a well-integrated system of care. Because of its familiarity and partnership with a broad spectrum of existing programs, interagency agreements, interagency work groups, and advocacy groups that promote child health and development, ECCS promises to be a valuable asset as Florida designs and implements a maternal and child health system to meet the needs of our communities.

The recently formed ECCS Multi-Agency Team is a collaborative group that meets quarterly and consists of key agency leadership representing child serving agencies, family advocacy representatives, and other community organizations. The ECCS Coordinator and its Multi-Agency Team are represented on several cabinet workgroups which address the issue of children's health.

Child Abuse Prevention and Permanency (CAPP) Advisory Council

In 2007, the Florida Legislature created the Office of Adoption and Child Protection in the Governor's Office which established a Child Abuse Prevention and Permanency (CAPP) Advisory Council to assist in the development and implementation of an action plan to prevent child maltreatment. Consistent with the Community-Based Child Abuse Prevention (CBCAP) requirements for primary and secondary prevention strategies, Florida recognizes home visiting as a strategy for offering information, guidance and emotional and practical support directly to families in their homes. As evidenced in the Florida Child Abuse Prevention and Permanency Plan: July 2010 - June 2015, Florida has recognized the need to infuse protective factors within home visiting programs throughout the state. Home visiting focuses on promoting positive parent-child interactions and healthy child development, while enhancing family functioning and problem-solving skills.

Strengthening Families Five Protective Factors

- **Nurturing and attachment**
- **Knowledge of parent and child and youth development**
- **Parental resilience**
- **Social connections**
- **Concrete supports for parents**

Each judicial circuit was also charged with creating a local planning team to develop a local action plan. The *Florida Prevention of Child Abuse, Abandonment, and Neglect Plan: July 2010 – June 2015* was developed by the Governor's Office of Adoption and Child Protection with the

assistance of the CAPP Advisory Council and fifteen workgroups with statewide representation. The local plans developed by the circuit teams are incorporated into the five year state plan.

This five year plan seeks to build the capacity for Floridians to prevent child maltreatment before it ever occurs. To do this, Florida's five-year child maltreatment prevention strategies focus on building resilience in Florida families. A *Strengthening Families* approach is being utilized which infuses the *Five Protective Factors* into an array of programs and services, including home visiting services.

The plan calls for Florida to build the capacity of parenting and support programs and services to incorporate the *Five Protective Factors* as a foundation for their work. Members of the home visiting programs throughout Florida are currently serving on a workgroup with the CAPP to achieve this goal in each of their respective programs. The Florida MIECHV Program will continue to explore the alignment of these efforts into existing and new HV programs in the communities.

State Agencies

As shown in the Early Learning System diagram, there are numerous state agencies charged with the provision of services to children and families. For Florida's HV Program, the primary two entities will be the Department of Health and the Department of Children and Families.

Department of Health

In 2010, then Governor Charlie Crist designated the Department of Health to be the lead agency to administer the MIECHV Program. The Department of Health is directed by the State Surgeon General, who answers directly to the Governor. The Surgeon General is responsible for overall leadership and policy direction of the department. The Department of Health is responsible for the administration of programs carried out with allotments under Title V of the Social Security Act. Many of these programs fall within the auspices of the Division of Family Health Services and the Division of Children's Medical Services. The directors of these two divisions serve as the primary Title V contacts for the state, and play an important role in the Title V direction.

The Division Director of Family Health Services provides leadership, policy, and procedural direction for Family Health Services, which includes the bureaus of Family and Community Health, WIC and Nutrition Services, Public Health Dental, Chronic Disease Prevention and Health Promotion, and the Child Nutrition Program.

The Bureau of Family and Community Health is responsible for many of the Title V activities related to pregnant women, mothers, infants and children. The Chief of the Bureau of Family and Community Health directs the offices of Infant, Maternal, and Reproductive Health (IMRH); Child and Adolescent Health; and Adult and Community Health. It is within this bureau that the MIECHV Program will be administered.

Additional partners within the Department of Health will include: the Office of Injury Prevention, ECCS, Healthy Start, Women, Infant and Children, Children's Medical Services Network, and county health departments.

Department of Children and Families

The Department of Children and Families (DCF) is Florida's social service agency and provides a wide variety of programs and services in the areas of child welfare, economic services, substance abuse, mental health, and adult services.

The Department's mission is to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency. The Department defines its customers as those families with children accessing and receiving services through one or more programs funded by general revenue.

As directed by the 1996 Legislature, the state began outsourcing the provision of foster care and related services statewide in an effort to encourage communities and stakeholders to become partners in the safety, permanency and well-being of Florida's children. Lead social service agencies throughout the state continue, in partnership with the Department through contracts, the provision of services in a specific geographic area, and oversee the provision of services in a community, county or judicial circuit.

The Office of Adoption and Child Protection initiated efforts to convene local planning teams in each of the twenty circuits around the state. These circuits are aligned geographically with the judicial and DCF circuits. The representation of these local planning teams in consistent with the make-up of the statewide Advisory Council. By October 2007, each circuit had established a local planning team that was convened by the circuit administrator and or a key leader in the circuit's administration.

The Department of Health has entered into a Memorandum of Agreement (MOA) with the Florida Department of Children and Families. This MOA outlines the individual and collective responsibilities in working together to complete this state plan and co-develop an effective home visiting program in Florida.

Other State Agencies

Both the Florida Department of Education and the Agency for Workforce Innovation are involved with Florida's early education efforts. The Agency for Health Care Administration oversees Medicaid, which will be critical as Florida defines the key components of its system of care. Peripherally, both the Department of Juvenile Justice and the Florida Department of Law Enforcement have prevention efforts that will be taken into consideration.

Both the Department of Health and the Department of Children and Families have initiated Memoranda of Agreements with the Department of Education, Office of Early Learning; Florida Department of Law Enforcement, and the Department of Children and Families (Mental Health, Substance Abuse, Office of Family and Community Services, and Child Care program) for the purposes of developing a collaborative MIECHV Task Force and for administrative data collection. However, due to the recent change in Florida's Governor and agency administration, obtaining signatures from each of these agencies was not possible in the time frame required to submit the State Plan. See Appendix 10 for the initiated agreement between the Department of Health and the Department of Children and Families. Efforts continue to obtain these signatures.

Additional Collaborative Partners

Collaborations and partnerships were strengthened during the Needs Assessment process, and both the DOH and the DCF are committed to continuing to extend and expand these collaborative efforts to all parties who share the commitment for improving the lives of pregnant women, infants, and children in need. During the implementation phase, the HV leadership team will reach out to additional groups such as educators, medical providers, community groups, those involved with the ECCS, Florida Medical Association, and others providing services to the population in need of home visiting services, to build effective, integrated systems of care in each community implementing a successful MIECHV Program.

To show Florida's commitment to the program, the Department obtained Memoranda of Concurrence from the directors of Florida's:

- Title V agency;
- Title II of the Child Abuse Prevention and Treatment Act;
- Child Care and Development Fund; and
- State Advisory Council on Early Childhood Education and Care

These memoranda can be found in Appendix 10.

State Funded Entities

Florida funds two community-based programs, Healthy Start and Healthy Families Florida, which are the foundation of Florida's prevention services.

Healthy Start

For almost 20 years, the Florida Department of Health has been working closely with local communities to improve the outcomes for pregnant women and infants. Florida's Healthy Start Initiative was implemented in 1992 to reduce infant mortality, reduce the number of low birth weight babies and improve health and developmental outcomes. In Florida, all pregnant women and infants are statutorily required to be offered screening for potential risks as soon as they enter the health care system. The screening instruments include assessments for risk factors based on medical, environmental, and psychosocial concerns. Pregnant women are screened at their first prenatal appointment. Infants are screened at the birthing facility based on information obtained from the birth certificate. Healthy Start services are available for all pregnant women and infants who are screened to be at risk for adverse health outcomes or who are referred due to special risk factors.

The Florida Department of Health contracts with 33 Healthy Start coalitions that serve 66 counties to implement the Healthy Start program. Desoto County Health Department provides the Healthy Start services in Desoto County, ensuring statewide coverage. Coalitions conduct assessments of community needs and resources and provide community education and outreach activities aimed at helping pregnant women and infants access health care and reduce factors which could negatively impact birth and developmental outcomes. Healthy Start services are provided through contracts or memoranda of agreement between the Healthy Start coalitions and private and public providers throughout the state. Services and outcomes are tracked via a web-based data system. Adherence to the program standards and guidelines is

ensured through training and technical assistance. Community providers receive annual quality assurance monitoring at the local level by the Healthy Start coalition and at the state level by program office staff with expertise in maternal and child health. Coalitions submit quarterly reports to the state health office and receive annual on-site monitoring for compliance with contractual requirements and performance measures. This well established system is being considered as a single point of entry for families in the MIECHV Program. Four of the five initial community MIECHV efforts are being administered through the local Healthy Start Coalitions.

Healthy Families Florida

Healthy Families Florida (HFF) was established in July 1998 with an appropriation to the Department of Children and Families. Healthy Families Florida is the single largest funded voluntary child abuse and neglect prevention program in the state. The DCF contracts with the Ounce of Prevention Fund of Florida, Inc., a private, non-profit corporation, to administer the HFF program. Healthy Families Florida completed a rigorous review process to demonstrate that the voluntary home visiting program has met nationally established, research-based standards that ensure quality service delivery. The program is recognized by Prevent Child Abuse America/Healthy Families America as a nationally accredited multi-site program. A multi-site accreditation means that all Healthy Families Florida projects within the statewide system are recognized as providers of high quality home visitation services and has a strong central administration to support the projects.

The HHF central office is responsible for providing oversight and program support to individual projects, thereby creating a network of projects operating under uniform criteria and toward the same goals. Its responsibilities include fiscal and data management, independent evaluation, training, technical assistance, quality assurance and program development. Healthy Families Florida's activities and outcomes are tracked and measured through a web-based data system. The Department of Children and Families is responsible for contract management and data support for evaluation. Healthy Families Florida projects are operated locally by independent community-based organizations. An independent five-year evaluation of the HFF program concluded that it had a significant impact on preventing child abuse and neglect in Florida's high-risk families.

Healthy Families Florida was designed to work in a complementary relationship with the Healthy Start program, and a close, effective relationship has evolved. The two programs developed a joint prenatal screen which determines eligibility for both programs. Healthy Families Florida and Healthy Start serve in collaboration as "the entry point" for prevention services. In communities where both HFF and Healthy Start are operating, program staff meet regularly to promote coordination of services and to resolve system issues. One of the initial community MIECHV programs is administered by the local Healthy Families provider.

Florida's Home Visiting Task Force

The federal home visiting program will be jointly administered by the HV Program Team and will draw from the experience of both agencies to manage the federal grant and build on the infrastructure already in place. The Home Visiting Task Force and a separate Coalition will serve in an advisory capacity.

The MIECHV Program will be imbedded within Florida's early childhood system of care that encompasses all efforts to promote the well-being of children and families. In order to ensure that the home visiting program is aligned with other state early childhood initiatives, a State Home Visiting Task Force will be created to serve as an advisory group to the MIECHV leadership team and program staff. The Task Force will have representation from state advisory councils, state agencies providing services to children and families, family and children's advocates, and consumers. The Chairperson of the Florida Home Visiting Coalition will also serve on the Task Force. The designated co-leaders from DOH and DCF will facilitate the Task Force meetings. Table 6.1 shows the agencies and entities that will be invited to participate as Task Force members. It is expected that the Task Force will be convened within 90 days of submission of the State Plan.

The proposed functions of the State Home Visiting Task Force will be to:

1. Advise and assist the lead agencies in the development and implementation of policies that ensure coordination of home visiting services at the state and local level.
2. Advise and assist the lead agencies to develop an over-arching statewide strategy to ensure and promote the effectiveness of the home visiting program.
3. Promote evidence-based home visiting programs as a key component of a high quality comprehensive statewide early childhood system of care.
4. Link the home visiting program to other efforts focused on promoting optimal child health and development to promote the development of effective local systems of care.
5. Strengthen mechanisms for interagency and cross program collaboration.
6. Coordinate planning among state agencies to promote a continuum of integrated and comprehensive services for children through adoption of common benchmarks and shared data.
7. Make recommendations to improve the continuum of services and eliminate duplication.

Table 6.1: Florida's Home Visiting Task Force
Advocates
Agency for Health Care Administration
Agency for Workforce Innovation
Children's Cabinet
Consumers
Department of Health
Department of Children and Families
Department of Education
Department of Juvenile Justice
Families
Florida Coalition Against Domestic Violence
Florida Department of Law Enforcement
Florida Head Start Collaboration Office
Home Visiting Coalition Chair

Florida's Home Visiting Coalition

The Florida Home Visiting Coalition membership includes representatives from programs throughout the state which have a home visiting component. To date, the Coalition has created a vision statement, gathered baseline data, conducted a survey of collaboration among the existing home visiting programs, mapped geographic locations of existing home visiting programs, inventoried a list of available trainings, and created a steering committee with bi-

weekly calls. The coalition is currently working on infusing the *Strengthening Families' Five Protective Factors* for reducing the incidence of child abuse and neglect into all the home visiting programs. The Home Visiting Coalition will assist the state leadership team with identifying core knowledge areas for all home visitors and help to facilitate regional trainings. The coalition will also serve as a conduit of information between the local communities and the State Home Visiting Task Force as to systemic issues that need to be addressed at the state level.

SECTION 7: PLAN FOR CONTINUOUS QUALITY IMPROVEMENT

Continuous Quality Improvement (CQI) is an ongoing organizational process in which all stakeholders are involved with identifying, planning and implementing various improvements in the delivery of the home visiting services provided. It is also a process of using internal and external data to assist in the decisions made to create an environment in which the administration, communities, and agency staff work collaboratively to improve all aspects of the MIECHV Program.

DATA TO BE COLLECTED

As described in Section 5, qualitative and quantitative data about program implementation at the state, community, and agency level will be obtained from several sources.

State Level

For the state-level implementation, meeting summaries and other documents will be reviewed, summarized and analyzed using the state plan as a benchmark for implementation progress. The web-based case management system will serve as a data source for benchmark indicators as well as for monitoring process indicators, such as local model enrollment and retention rates for the community and for individual home visitors. It will serve as the principal data source for the Continuous Quality Improvement of Florida's MIECHV Program.

The web-based system will capture data required by Florida's MIECHV Program and by each of the national offices of the home visiting programs being implemented. Likewise, data will be uploaded on a regular basis into the Comprehensive Birth Registry System. This registry will also be used to analyze data for all constructs as required by HRSA, and to determine comparisons between program participants' outcomes and expected outcomes or those for a matched comparison group.

Agency and Community Levels

To supplement data entered in the web-based case management system by the local agencies, reports from the agencies will be submitted to the evaluation team on a quarterly basis. As described in detail in Section 5, many process variables can be evaluated from these two sources of data, including, but not limited to:

- What kinds of services are being provided?
- What is the attrition rate?
- How is coordination of care actually working?
- What are the demographic characteristics of the population being served?
- How do the demographic characteristics relate to national model criteria and the MIECHV criteria?
- How close to capacity is the local program operating?
- Is the program on track for national accreditation?

Further process analysis of the communities will be based on three additional sources of data: annual administration of a customer survey; the CDC's PARTNER survey; and annual site visits to the communities.

Client satisfaction surveys will be conducted annually by the evaluation team to obtain feedback from families on their experiences in the HV programs. Surveys conducted by the programs for their own QI assessment will be reviewed by the evaluation team as well. These surveys will be used to determine technical assistance needs that would improve performance by the HV program and or community partners.

USE OF THE DATA TO CONDUCT CONTINUOUS QUALITY IMPROVEMENT

The evaluation team will combine all the information collected and analyze the state, community and agency level data. Based on that analysis, quarterly reports will be prepared for agency and departmental staff to serve as the basis for technical assistance efforts, training topics, and CQI opportunities.

The quarterly reports received from agencies will also include their suggestions to the departments on how state level administrators can provide better or additional technical assistance.

Continuous Quality Improvement Teams

Recognizing that home visitors and parents are vital pieces in the program, it is the Departments' intent to involve employees at all levels in order to improve processes and activities required to accomplish the goals and objectives. Along with the state and community administrators, valuing the front line experts to identify problem areas and suggest solutions is key to the CQI efforts.

There will be a CQI team at the state level as well as in each implementing community. At the state level, it is expected that the evaluation team will act as the lead to facilitate CQI meetings and coordinate input and feedback to staff.

A MIECHV staff member will act as a scribe to create detailed meeting summaries and record the process, decisions made, and activities to be accomplished. The remainder of the CQI team will include the MIECHV leadership team members with additional data administrators who work closely with the data generated by state agencies. This CQI team will meet at least quarterly and will use the results of the evaluation team's reports as a starting point for agenda discussion items.

At the local level, it is planned that the agencies in each community will include staff from all levels within the agency representing all programmatic service areas as well as community stakeholders, including parents. As with the state CQI team, the local group can meet quarterly using the results of the evaluation team's quarterly report to guide their discussion. A member from the state CQI team will join the local meetings via conference call.

MEASURING CQI

The evaluation team will guide the discussions in setting the target expectations for the communities as well as the state Program's achievement of its stated goals and objectives in order to meet the benchmarks set forth in this State Plan. As stated earlier, the evaluation team will incorporate quarterly reports from communities and all administrative data to determine progress toward the targeted statewide expectations and objectives.

As documented in Section 5, it is expected that the state's progress can be measured by determining:

1. How agency staff is interacting with communities and national offices to solve problems and ensure the success of Florida's MIECHV Program.
2. The systems the state has in place to manage the Program and how they are being implemented.
3. The level of collaboration among state agencies and other statewide organizations.
4. The extent to which those collaborations facilitate program implementation.

These results will be shared with the two Departments with recommendations and solutions.

At the local level, reports will also be developed for the community agencies that show their current status as compared to the other HV programs including trends over time. Having these data allows agencies to see where they are in comparison to their counterparts in other parts of the state. This sharing of data will permit all involved participants to be aware of progress and to have a say in modifications needed to move forward.

In conclusion, the sources of information in this section will provide information from the state, community and agency levels documenting the implementation of Florida's MIECHV Program and allow for careful observation, monitoring and adjustment of activities at all three levels to ensure success in meeting the goals and objectives of the program and ultimately achieving the benchmarks set forth by legislation.

SECTION 8: TECHNICAL ASSISTANCE NEEDS

FLORIDA'S NEEDS FROM HRSA

It is anticipated that as Florida moves forward in implementing the MIECHV Program, that assistance on a variety of topics from the HRSA would be beneficial. Technical support and guidance from the HRSA to define measures of program quality is anticipated as a major component of the implementation phase. Florida seeks to improve this quality aspect dramatically in the future by working closely with the HRSA and statewide experts in the field of evidence-based home visiting models to establish clearly defined short- and long-term outcomes and performance measures, including assessing client satisfaction using both quantitative and qualitative methods.

As efforts to plan for the evaluation methods to measure the benchmarks, initial concerns have arisen that the number of assessments required to obtain the necessary information, will require considerable time for the home visitor to administer and could inadvertently affect the fidelity of the models by increasing the number of visits required. For example, in order to measure parent knowledge of child development, the only tool identified to measure this construct is the *Knowledge of Infant Development Inventory (KIDI)* which is a seventeen question scale.

Additionally, the Departments' greatest need will be building the data collection and reporting system across multiple local and state agencies for all of the domains, constructs, and indicators. While efforts are underway to address these tasks, technical assistance in this area, specifically with regard to client confidentiality and privacy concerns will be requested. Continuing to convene conference calls that involve data leads for each state is an excellent first step in providing this technical assistance.

The Florida's Child Abuse Prevention and Permanency Plan July 2010 – June 2015 emphasizes the importance of evidence-based parenting curricula in community programs providing services to families. Research and direction by HRSA would assist the Departments in obtaining and using the most appropriate curricula available for dissemination, particularly when promising practice models are melded into the Program.

PROVISION OF TECHNICAL ASSISTANCE TO COMMUNITIES

It is the intent of the Departments to provide technical assistance to the communities in hopes of building core competencies across the program models. The Departments will look to the Home Visiting Coalition (HVC) for guidance in the area of professional development. The HVC recently completed an inventory of all the training curricula amongst the different models. A thorough review to identify gaps or missing topics will be conducted to provide a snapshot of needs to be addressed. Core competency skills that all home visitor professionals should use will be identified and a search for such curricula will be conducted. A few of the potential topics considered appropriate to provide to all MIEC home visitors in addition to the model-specific training they will receive from the national organizations, could include, but is not limited to:

- Mental wellness activities or training to manage loss and to improve coping strategies
- Impact of adverse childhood experiences
- Maternal depression
- Safe sleeping for infants
- Working with substance using parents
- Infant mental health
- Negotiating with parents
- Motivational interviewing
- Setting goals and support plans with families
- Family team conferencing strategies
- How to create a quality family support plan
- How to integrate the home visiting program with other community services
- How to build a treatment team to best serve the needs of the family

Additionally, both departments have developed numerous training curricula related to maternal and child health, substance abuse, mental health, child development and wellbeing, etc. A review of these trainings will be conducted so that appropriate curricula can be made available to the community programs. These training opportunities as well as the selected core competency topics will be made available to the community programs, either via links to the training on the MIECHV Program website, formal Webinars or in formal face-to-face trainings.

Based on quarterly reports provided by the evaluation team and derived from the web-based case management tool and from template responses provided by communities, agency staff will offer customized technical assistance to help community implementers overcome obstacles and promote continuous quality improvement.

SECTION 9: REPORTING REQUIREMENTS

The DOH will submit an annual report to the Secretary of Health and Human Services (HHS) that will include a review of progress made towards accomplishment of goals and objectives; an update of implementation of the home visiting program in at-risk communities; a report of progress towards capturing legislatively mandated benchmarks and their respective constructs; a progress report on Florida's CQI efforts; and updates on the administration of the state's home visiting program.

Data sources for this report will include process and outcome indictors collected through a web-based case management system from all service providers funded by the MIECHV Program; quarterly qualitative reports collected from all communities implementing models; onsite monitoring of implementation; and documentation maintained by state agencies regarding program progress.

The annual report will be provided when requested by the HHS Secretary and in a format consistent with requirements.

APPENDICES

APPENDIX 1

HOME VISITING ADVISORY COMMITTEE MEMBER ROSTER

2010 MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

Advisory Committee Members

Name	Title	Contact Information	Representing
Carol Scoggins Co-Chair	Program Administrator, Infant, Maternal and Reproductive Health	Florida Department of Health 4025 Esplanade Way, Bin A-13 Tallahassee, FL 32399 850-245-4103 Carol_Scoggins@doh.state.fl.us	Health
Dee Richter Co-Chair	Child Welfare Director	Florida Department of Children and Families Office of Family Safety 1317 Winewood Blvd. Tallahassee, FL 32399-0700 850-922-6306 Dee_Richter@dcf.state.fl.us	Child Welfare
Randell Alexander	Statewide Child Protection Team Director	4539 Beach Blvd Jacksonville, FL 32207 WK 904-633-0190 Cell 904-655-9505	Health and Child Welfare
Estrellito "Lo" Berry, MA, LTFP	President, REACHUP, Inc. President, National Healthy Start Association BOD	Central Hillsborough Healthy Start Project 10500 University Center Drive, Suite 100 Tampa, FL 33612 813-712-6301 Fax: 813-971-3000 lberry@reachupincorporated.org	Health and Child Welfare
Brittany Birken	Director, Office of Early Learning	Agency for Workforce Innovation 107 East Madison Street Tallahassee, FL 32399-4120 Phone: 850-921-3198 Email: Brittany.Birken@flaawi.com	Child Welfare
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Lilli Copp	Director	Florida Head Start State	Child Welfare

Name	Title	Contact Information	Representing
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Ed Feaver	Director	Whole Child 115 Byrd Road Quincy, FL 32351 850-627-2457 ed_feaver@comcast.net	Child Welfare
Mimi Graham	Director	Center for Prevention and Early Intervention Policy Florida State University 1339 East Lafayette Street Tallahassee, Florida 32301 Office: (850) 922-1300 mgraham@fsu.edu	Health
Ted Granger	President	United Way of Florida 307-B East 7th Avenue Tallahassee, FL 32303 Phone: 850-488-8287 tgranger@uwof.org	Child Welfare
Jim Kallinger	Governor's Children's Cabinet Child Advocate	Office of Governor Charlie Crist State of Florida The Capitol Tallahassee, FL 32399-001 Phone(850)921-2015 Jim.Kallinger@myflorida.com	Child Welfare

Name	Title	Contact Information	Representing
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Carol McNally	Executive Director	Healthy Families Florida Ounce of Prevention Fund of Florida 111 N. Gadsden Street, Suite 100 Tallahassee, FL 32301 Work Phone: (850) 488-1752 x129 Cell Phone: (850) 933-2974 cmcnally@ounce.org	Child Welfare
Jane Murphy	President	Florida Association of Healthy Start Coalitions, Inc. 2806 North Armenia Avenue, Suite 100 Tampa, Florida 33607 Phone (813)233-2800 JMurphy@hstart.org	Health/Child Welfare
Annette Phelps	Division Director	Florida Department of Health Family Health Services 4052 Bald Cypress Way A-13 Tallahassee, FL 32399 Annette_Phelps@doh.state.fl.us	Health
Lynn Marie Price	Children's Medical Services Early Steps	Bureau Chief Children's Medical Services 4025 Esplanade Way Tallahassee, FL 32399 LynnMarie_Price@doh.state.fl.us	Health
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APPENDIX 2

COMPOSITE RANKING OF HIGH-RISK COUNTIES

	Premature Births		Low Birth Weight Infants		Infant Mortality		Poverty		Crime		Domestic Violence		High School Dropouts		Substance Abuse: Service Needs		Unemployment		Child Maltreatment: Verified/Some Indication Findings					
	Average 2006-08		*Average 2006-08*		*Average 2006-08*		*0-4 Years Average 2006-08*		*Index Crime Average 2007-09*		*Offenses Average 2007-09*		*Average 2006-07 - 2008-09*		*Ages 15-44, Average 2006-07 - 2008-09*		*Average 2007-09*		*Infants Average 2007-09*		*Ages 1-4 Average 2007-09*		Composite Rank	
County	%	Rank	%	Rank	per 1,000	Rank	%	Rank	per 100,000	Rank	per 1,000	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	Average Rank	Rank
Putnam	13.7%	32	9.7%	11	7.6	30	39.3%	5	6,052	4	12.0	1	4.0%	17	11.0%	7	8.0%	12	7.7%	18	6.0%	10	13.4	1
Okeechobee	13.6%	35	9.5%	15	6.1	48	35.9%	11	3,899	25	7.1	19	4.8%	5	10.6%	17	8.5%	6	8.0%	15	5.4%	19	19.5	2
Escambia	16.7%	3	10.7%	6	8.6	15	28.6%	26	4,877	9	8.4	5	3.2%	25	11.6%	3	6.5%	40	6.3%	34	3.2%	58	20.4	3
Madison	14.8%	14	10.7%	5	7.7	25	36.7%	9	3,650	28	6.5	30	4.4%	12	11.0%	6	8.0%	13	4.3%	60	3.7%	44	22.4	4
Duval	14.7%	15	9.5%	14	9.4	12	20.3%	59	6,195	2	8.2	9	4.4%	11	10.4%	26	6.9%	35	6.9%	28	4.0%	41	22.9	5
Gadsden	15.2%	11	11.9%	1	12.9	4	39.4%	4	3,228	39	8.8	2	3.6%	21	10.5%	19	6.8%	37	3.7%	62	3.1%	59	23.5	6
Alachua	13.6%	38	9.1%	21	8.3	17	22.4%	46	5,082	8	6.8	23	4.4%	14	13.1%	2	4.8%	65	10.8%	6	5.2%	24	24.0	7
Marion	12.9%	52	8.4%	34	9.6	11	32.5%	18	3,238	36	8.3	7	3.0%	27	9.9%	44	8.4%	8	8.1%	14	5.9%	15	24.2	8
Hardee	14.6%	16	8.2%	40	10.2	8	36.8%	8	3,511	30	6.7	26	5.4%	2	10.8%	10	7.3%	23	4.7%	53	3.3%	57	24.8	9
Pinellas	12.9%	51	8.6%	31	8.4	16	21.6%	50	5,114	7	8.3	8	2.5%	33	10.6%	15	7.0%	33	10.5%	7	5.1%	26	25.2	10
Hamilton	16.8%	2	11.6%	2	19.0	1	39.7%	3	2,819	46	3.8	54	4.4%	13	10.7%	13	7.6%	16	3.0%	64	2.8%	64	25.3	11
Highlands	14.2%	22	7.6%	53	6.4	41	33.7%	15	3,238	37	4.8	44	4.6%	9	10.2%	32	7.6%	15	10.1%	8	6.2%	9	25.9	12
Polk	13.7%	31	8.2%	42	7.6	29	27.4%	31	4,329	17	8.6	4	4.0%	16	10.0%	40	7.5%	18	6.8%	30	4.8%	31	26.3	13
Bay	13.6%	36	8.2%	41	8.0	23	24.6%	37	4,688	12	8.1	11	1.7%	49	10.6%	18	6.1%	47	9.6%	11	6.5%	6	26.5	14
Columbia	13.9%	27	8.8%	26	12.8	5	32.4%	19	4,375	16	7.4	18	1.2%	59	10.3%	30	6.1%	45	7.2%	25	5.2%	23	26.6	15
Manatee	12.6%	56	7.5%	57	7.6	28	23.5%	39	5,363	6	8.8	3	3.1%	26	10.0%	41	7.4%	20	9.7%	10	6.4%	8	26.7	16
Taylor	13.7%	34	10.1%	8	9.6	10	29.3%	25	3,402	33	7.4	17	3.9%	18	9.5%	56	7.2%	26	6.1%	36	3.7%	46	28.1	17
Hendry	16.1%	6	8.9%	23	7.3	31	31.8%	21	4,225	19	5.1	38	3.4%	23	10.5%	20	10.8%	1	2.7%	66	2.5%	65	28.5	18
Desoto	13.2%	47	6.7%	67	6.2	45	38.8%	6	4,014	23	8.0	13	4.0%	15	10.7%	12	7.2%	28	7.4%	22	4.2%	40	28.9	19
Bradford	13.4%	43	9.5%	13	9.3	13	26.0%	35	2,701	48	7.0	21	4.4%	10	10.5%	24	5.4%	57	5.7%	42	5.9%	14	29.1	20
Dixie	12.7%	55	7.9%	46	5.5	56	35.1%	13	4,253	18	4.6	50	4.6%	8	10.8%	11	7.7%	14	6.9%	29	5.2%	20	29.1	20
Osceola	13.9%	26	8.6%	30	8.6	14	21.1%	55	4,391	15	8.1	10	2.7%	31	9.1%	64	7.3%	25	6.7%	31	5.2%	21	29.3	22
Levy	13.1%	49	6.9%	63	9.6	9	34.7%	14	3,620	29	8.4	6	3.8%	19	10.1%	37	7.6%	17	5.1%	49	4.6%	34	29.6	23
Hernando	12.5%	57	7.6%	55	6.6	40	26.9%	32	3,807	26	6.7	27	2.9%	29	9.6%	53	9.2%	4	13.4%	1	9.0%	3	29.7	24
Lake	14.2%	21	8.0%	44	7.9	24	23.4%	41	3,274	34	6.5	29	3.5%	22	9.4%	58	7.2%	27	7.5%	19	6.0%	13	30.2	25
Brevard	14.8%	13	8.6%	29	7.0	37	19.7%	60	3,974	24	7.1	20	0.7%	65	10.4%	25	7.1%	32	8.5%	13	5.7%	17	30.5	26
Holmes	13.4%	42	7.4%	58	12.4	6	33.1%	16	1,575	60	4.4	52	2.5%	34	10.7%	14	5.5%	54	12.0%	2	9.5%	1	30.8	27
Volusia	12.1%	60	8.3%	37	8.2	21	28.0%	29	4,213	20	7.6	16	1.2%	60	10.8%	9	7.2%	29	7.3%	23	4.6%	36	30.9	28
Orange	15.3%	10	9.2%	18	8.2	19	18.4%	61	6,202	1	8.0	12	1.4%	56	10.2%	34	6.7%	38	5.9%	38	3.4%	54	31.0	29
Suwannee	13.3%	44	7.0%	62	13.3	3	35.2%	12	2,642	49	6.8	24	5.2%	4	10.9%	8	6.4%	42	4.4%	57	4.4%	38	31.2	30
Jackson	13.8%	30	10.0%	9	7.2	33	28.2%	27	2,381	53	4.7	46	1.6%	50	10.4%	27	5.5%	55	11.0%	5	6.0%	12	31.5	31
Citrus	11.6%	63	7.7%	51	5.5	55	36.0%	10	2,417	52	7.0	22	2.3%	37	10.0%	43	8.5%	7	11.1%	4	8.4%	4	31.6	32
Glades	14.5%	17	9.9%	10	3.5	65	32.6%	17	2,964	45	7.8	14	7.3%	1	9.6%	54	7.2%	31	4.7%	52	3.6%	47	32.1	33

	Premature Births		Low Birth Weight Infants		Infant Mortality		Poverty		Crime		Domestic Violence		High School Dropouts		Substance Abuse: Service Needs		Unemployment		Child Maltreatment: Verified/Some Indication Findings					
	Average 2006-08		*Average 2006-08*		*Average 2006-08*		*0-4 Years Average 2006-08*		*Index Crime Average 2007-09*		*Offenses Average 2007-09*		*Average 2006-07 - 2008-09*		*Ages 15-44, Average 2006-07 - 2008-09*		*Average 2007-09*		*Infants Average 2007-09*		*Ages 1-4 Average 2007-09*		Composite Rank	
County	%	Rank	%	Rank	per 1,000	Rank	%	Rank	per 100,000	Rank	per 1,000	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	Average Rank	Rank
Leon	13.6%	40	9.6%	12	8.3	18	21.3%	52	4,848	10	4.7	45	2.9%	28	13.4%	1	4.9%	64	6.4%	33	3.3%	55	32.5	34
Pasco	13.2%	45	8.3%	38	6.2	46	26.4%	34	4,151	21	7.7	15	2.2%	38	9.5%	55	8.1%	11	6.4%	32	5.2%	25	32.7	35
Miami-Dade	15.6%	9	8.9%	24	6.0	49	22.2%	48	6,074	3	4.5	51	4.7%	7	10.5%	21	7.3%	24	2.8%	65	1.5%	67	33.5	36
Hillsborough	14.0%	23	9.1%	22	8.1	22	22.6%	45	4,582	13	6.7	25	1.4%	55	10.2%	33	7.0%	34	5.7%	44	3.4%	53	33.5	37
Palm Beach	14.3%	20	9.2%	20	5.9	52	21.1%	54	4,848	11	4.9	41	3.6%	20	10.2%	31	7.2%	30	5.7%	43	3.6%	48	33.6	38
Calhoun	13.6%	37	7.7%	52	13.4	2	32.2%	20	1,027	65	2.9	58	1.8%	48	10.3%	29	5.9%	52	7.5%	20	7.3%	5	35.3	39
Washington	13.6%	39	8.7%	28	3.6	64	40.2%	2	1,276	63	4.6	48	1.5%	54	9.7%	52	6.8%	36	11.6%	3	9.2%	2	35.5	40
Gulf	15.7%	8	11.6%	3	7.2	32	29.9%	23	1,894	57	1.3	66	1.2%	61	10.0%	38	6.5%	39	5.9%	39	5.1%	28	35.8	41
Walton	11.6%	64	8.8%	27	7.7	27	27.9%	30	2,463	51	6.4	31	2.2%	39	9.8%	49	4.9%	63	10.1%	9	6.5%	7	36.1	42
Baker	14.0%	24	8.8%	25	8.2	20	22.2%	47	1,570	61	2.5	60	2.2%	41	10.3%	28	6.5%	41	6.2%	35	5.2%	22	36.7	43
St Lucie	13.5%	41	8.4%	35	6.9	38	22.9%	42	3,497	31	6.0	33	1.6%	51	9.3%	61	9.3%	3	6.0%	37	4.6%	33	36.8	44
Sumter	17.5%	1	9.3%	17	5.7	53	28.1%	28	1,512	62	2.3	62	2.6%	32	8.2%	67	6.0%	49	7.3%	24	4.9%	30	38.6	45
Monroe	13.9%	28	8.1%	43	5.3	59	17.2%	64	5,617	5	5.1	39	0.8%	62	11.3%	5	4.5%	66	7.1%	27	5.0%	29	38.8	46
Jefferson	16.1%	5	11.1%	4	2.0	66	26.5%	33	2,305	54	1.4	65	5.2%	3	10.5%	23	5.5%	56	4.3%	59	2.9%	62	39.1	47
Franklin	14.4%	18	7.3%	60	5.4	57	37.0%	7	2,216	55	3.6	57	4.7%	6	8.4%	66	5.1%	59	7.7%	17	4.7%	32	39.5	48
Okaloosa	11.2%	65	7.8%	48	7.7	26	17.2%	63	3,100	43	5.3	36	1.5%	53	10.6%	16	4.9%	61	9.3%	12	6.0%	11	39.5	48
Broward	14.9%	12	9.3%	16	5.9	51	20.3%	58	4,578	14	4.2	53	2.4%	35	10.1%	35	6.0%	51	4.8%	51	2.8%	63	39.9	50
Union	16.1%	4	9.2%	19	11.2	7	23.7%	38	1,199	64	1.9	64	1.3%	58	9.7%	51	5.3%	58	5.7%	41	4.6%	35	39.9	50
Lee	14.0%	25	8.4%	33	6.7	39	20.4%	57	3,780	27	4.9	40	1.8%	46	9.2%	63	8.3%	9	4.6%	54	3.0%	61	41.3	52
Santa Rosa	13.8%	29	7.8%	47	7.1	34	21.2%	53	1,651	58	4.7	47	1.9%	45	10.0%	42	6.1%	48	7.1%	26	5.1%	27	41.5	53
Nassau	14.4%	19	8.0%	45	5.4	58	17.8%	62	3,440	32	5.6	34	3.3%	24	9.9%	46	6.1%	46	4.9%	50	3.5%	51	42.5	54
Clay	13.0%	50	7.6%	56	6.0	50	15.4%	66	3,100	44	6.6	28	1.8%	47	9.7%	50	6.0%	50	8.0%	16	5.4%	18	43.2	55
Flagler	12.1%	59	8.3%	39	5.7	54	25.7%	36	2,727	47	6.3	32	1.9%	44	8.5%	65	10.3%	2	4.0%	61	4.0%	42	43.7	56
Gilchrist	12.8%	53	8.3%	36	1.7	67	29.7%	24	1,616	59	4.6	49	0.8%	64	11.4%	4	6.2%	44	5.4%	46	4.3%	39	44.1	57
Indian River	11.1%	66	6.8%	66	7.1	35	22.9%	43	3,241	35	4.8	42	1.5%	52	9.9%	45	8.8%	5	5.1%	48	3.5%	50	44.3	58
Sarasota	12.4%	58	7.2%	61	3.7	63	20.6%	56	4,040	22	3.7	56	2.2%	40	9.8%	48	7.5%	19	7.4%	21	3.7%	45	44.5	59
Liberty	16.0%	7	10.2%	7	6.2	47	30.7%	22	-	67	0.0	67	0.5%	67	9.5%	57	4.3%	67	5.2%	47	4.5%	37	44.7	60
Collier	13.7%	33	6.8%	65	6.3	44	21.6%	49	2,172	56	5.4	35	2.4%	36	10.1%	36	7.4%	22	3.4%	63	2.2%	66	45.9	61
Charlotte	12.8%	54	7.7%	50	4.7	62	22.7%	44	3,131	42	2.9	59	2.0%	42	9.9%	47	8.3%	10	5.8%	40	3.1%	60	46.4	62
Wakulla	11.8%	62	8.4%	32	6.3	43	23.4%	40	2,512	50	2.1	63	2.8%	30	9.3%	59	4.9%	62	4.5%	56	5.9%	16	46.6	63
Seminole	13.1%	48	7.6%	54	6.3	42	16.1%	65	3,153	40	5.2	37	0.8%	63	10.0%	39	6.3%	43	5.4%	45	3.9%	43	47.2	64
Martin	13.2%	46	7.4%	59	5.3	60	21.5%	51	3,146	41	4.8	43	0.6%	66	10.5%	22	7.4%	21	4.4%	58	3.3%	56	47.5	65
Lafayette	12.1%	61	7.8%	49	7.1	36	41.6%	1	891	66	2.5	61	1.9%	43	9.2%	62	5.1%	60	1.8%	67	3.6%	49	50.5	66
St Johns	10.9%	67	6.9%	64	4.8	61	13.9%	67	3,234	38	3.7	55	1.4%	57	9.3%	60	5.6%	53	4.5%	55	3.5%	52	57.2	67

APPENDIX 3

HEALTHY START INFANT AND MATERNAL RISK SCREENS

INFANT RISK SCREEN

Use ink. Be certain to check the appropriate boxes at the top of the birth certificate.

Pursuant to § 383.14(1)(b) and 383.011(1)(e), F.S., this form must be completed for each infant and submitted to the local County Health Department, Office of Vital Statistics.

MOTHER

Mother's Name: First Last Maiden

Mother's Date of Birth | Mother's Social Security Number

INFANT

Infant's Name: First Last | Infant's Date of Birth | Boy | Girl

Name of Infant's Doctor/ HMO or Group: _____ Name of birth hospital/facility: _____

Was the infant transferred? ☐ No ☐ Yes If Yes, enter name of facility transferred to: _____

Was the infant admitted to neonatal intensive care unit for more than 24 hours? ☐ No ☐ Yes ☐ Unknown

SECTION 1: COMPLETED BY PATIENT

Yes_____ No_____ (please initial) I am interested in having my infant screened for risks that could affect his/her health or development in the first year of life.

Yes_____ No_____ (please initial) If my infant is referred, Healthy Start may contact me.

I can be reached at (home phone): _____ or (work or contact phone): _____

Street Address: _____

(Give either street address with bldg.#, apt.# or lot# or directions to baby's home)

Mailing Address: _____

(if different from street address)

Yes_____ No_____ (please initial) By initialing yes, I am giving my written permission on behalf of my infant for release of the confidential information on this form and any information provided during his/her evaluation for service by Healthy Start to Healthy Start care coordination providers, Healthy Start Coalitions, Healthy Families Florida, WIC, and my health care providers for the following purposes: care coordination, payment of claims for services, quality improvement of services, or screening for program eligibility. This includes any medical, mental health, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information. This authorization shall remain in effect unless withdrawn in writing.

_____ _____

Signature of parent or guardian **Date (mo/day/yr)**

SECTION 2: BY PROVIDER

All item numbers correspond to the numbers on the Birth Certificate. Write the point(s) on the appropriate lines, and add for the total score.

Item 16	⊙____	**Mother's age is less than 18 or unknown**
Item 32	⊙____	**Mother is over 18 and mother's education is less than 12th grade or unknown**
Item 30	⊙____	**Mother's race is unknown, other than white, or multiple races selected**
Item 15	⊙____	**Mother is not married**
Item 36d	⊙____	**The number of prenatal visits is zero, one, or unknown**
Item 4	⊙____	**Infant's birthweight is less than 2000 grams or less than 4 pounds, 7 ounces**
Item 40	⊙____	**Mother used tobacco during pregnancy and number of cigarettes per day is more than nine or unknown**
Item 41	⊙____	**Mother used alcohol during pregnancy or alcohol use is unknown**
Item 54	⊙____	**Abnormal conditions of the newborn include hyaline membrane disease/RDS, or assisted ventilation required (for 30 minutes or more) or assisted ventilation required (for 6 hours or more)**
Item 55	⊙____	**Infant has one or more congenital anomalies**
	_____	**Infant's Healthy Start Screening Score**

CHECK ONE

☐ **Referred to Healthy Start based on score.**
☐ **Referred to Healthy Start based on factors other than score. Specify :** _____
☐ **Not referred to Healthy Start or Patient declined Healthy Start.**

BE CERTAIN TO CHECK THE APPROPRIATE BOXES AT THE TOP OF THE BIRTH CERTIFICATE.

I have explained the Healthy Start program, and if screened, the patient's screening score.

_____ _____

Provider's/Interviewer's Signature and Title **Date (mo/day/yr)**

NO ATTACHMENTS MAY BE ADDED TO THIS FORM.

DH 3135, 01/04 stock number 5744-100-3135-5
Distribution of copies: WHITE & YELLOW – With Birth Certificate
PINK– To Baby's File
GREEN – Parent's Copy

Addressograph Imprint

Help your baby have a healthy start in life!

Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are confidential. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in ink.)*

Today's Date: _____

	YES	NO
1. Have you graduated from high school or received a GED?	☐	☐ 1
2. Are you married now?	☐	☐ 1
3. Are there any children at home younger than 5 years old?	☐	☐
4. Are there any children at home with medical or special needs?	☐	☐
5. Is this a good time for you to be pregnant?	☐	☐
6. In the last month, have you felt down, depressed or hopeless?	☐ 1	☐
7. In the last month, have you felt alone when facing problems?	☐	☐
8. Have you ever received mental health services or counseling?	☐	☐
9. In the last year, has someone you know tried to hurt you or threaten you?	☐	☐
10. Do you have trouble paying your bills?	☐	☐

11. What race are you? Check one or more.
☐ White ☐ 2 Black ☐ Other _____

12. In the last month, how many alcoholic drinks did you have per week?
_____ drinks 1 ☐ did not drink

13. In the last month, how many cigarettes did you smoke a day? *(a pack has 20 cigarettes)*
_____ cigarettes 1 ☐ did not smoke

14. Thinking back to just before you got pregnant, did you want to be.....?
☐ pregnant now ☐ pregnant later ☐ 1 not pregnant

15. Is this your first pregnancy?
☐ 2 Yes ☐ No If no, give date your last pregnancy ended:
Date: (month/year)_____

16. Please mark any of the following that have happened.
☐ 1 Had a baby that was not born alive
☐ 1 Had a baby born 3 weeks or more before due date
☐ 1 Had a baby that weighed less than 5 pounds, 8 ounces
☐ None of the above

PATIENT INFORMATION

Name: First Last M.I.	Social Security Number:	Date of Birth (mo/day/yr): 17. Age:	☐ 1 <18
Street address (apartment complex name/number):	County:	City: State: Zip Code:	
Prenatal Care covered by: ☐ Medicaid ☐ Private Insurance _____ ☐ No Insurance ☐ Other _____	Best time to contact me:	Phone #1 _____ Phone #2 _____	

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: _____ **Date:** _____

Please initial: _____ Yes _____ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

** If you do not want to participate in the screening process, please complete the patient information section only and sign below:*

Signature: _____ *Date:* _____

PROVIDER ONLY

LMP (mo/day/yr):	EDD (mo/day/yr):	18. Pre-Pregnancy: Wt: _____lbs. Height: _____ft. _____in. BMI: _____	☐ 1 <19.8 ☐ 2 >35.0
Provider's Name:	Provider's ID:	19. Pregnancy Interval Less Than 18 Months? ☐ N/A ☐ No	☐ 1 Yes
		20. Trimester at 1st Prenatal Visit? _____	☐ 1 2nd
Provider's Phone Number:	Provider's County:	21. Does patient have an illness that requires ongoing medical care? Specify illness: _____ ☐ No	☐ 2 Yes
Healthy Start Screening Score: _____	**Check One: ☐ Referred to Healthy Start. If score <6, specify:** _____ **☐ Not Referred to Healthy Start.**		
Provider's/Interviewer's Signature and Title _____ **Date (mo/day/yr)** _____			

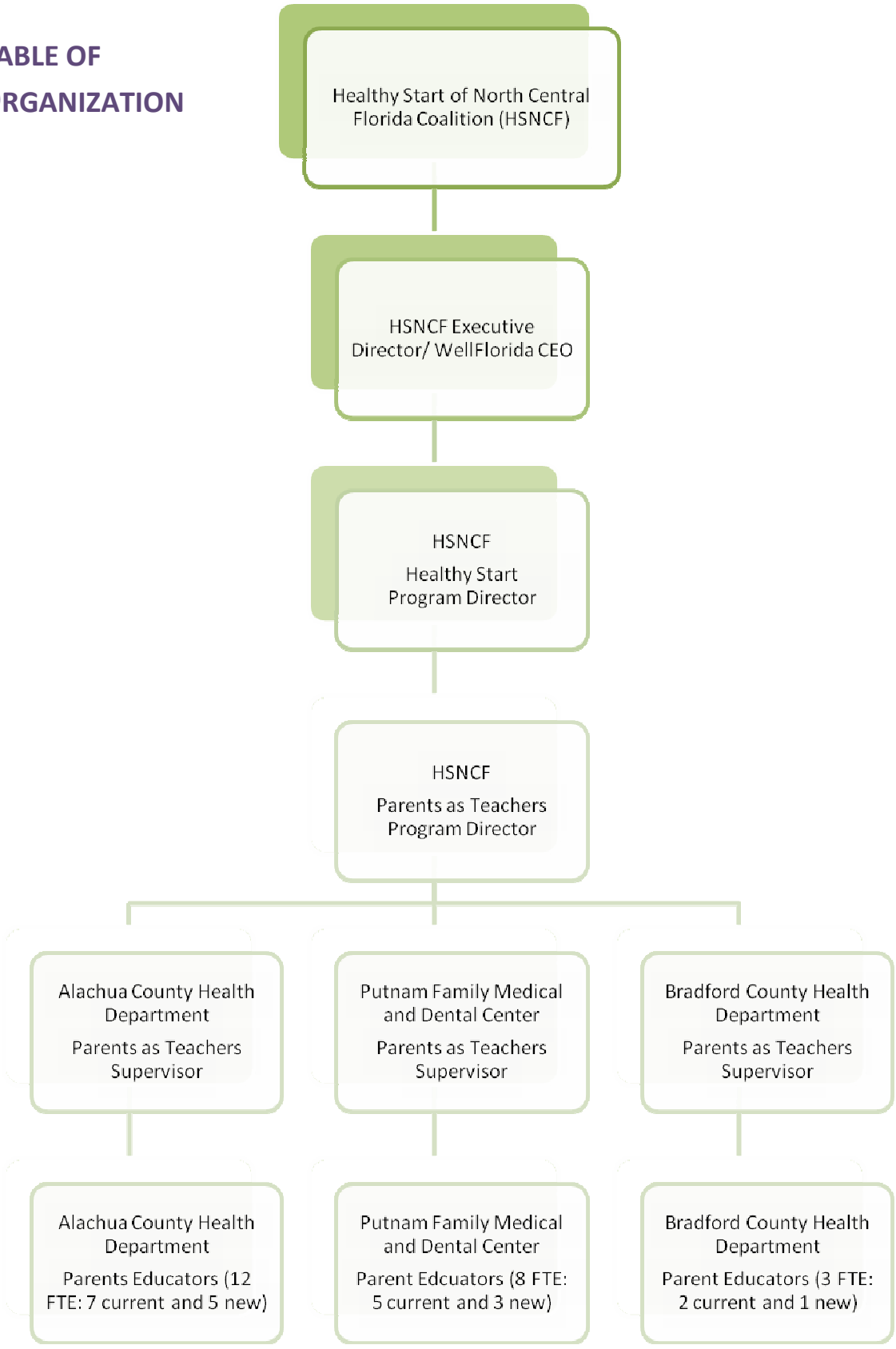
DH 3134, 04/08, stock number 5744-100-3134-7 Distribution of copies: WHITE & YELLOW—County Health Department in county where screening occurred PINK—Retained in patient's record GREEN—Patient's Copy

APPENDIX 4

SUPPORTING DOCUMENTS FOR

PUTNAM, BRADFORD AND ALACHUA COUNTIES

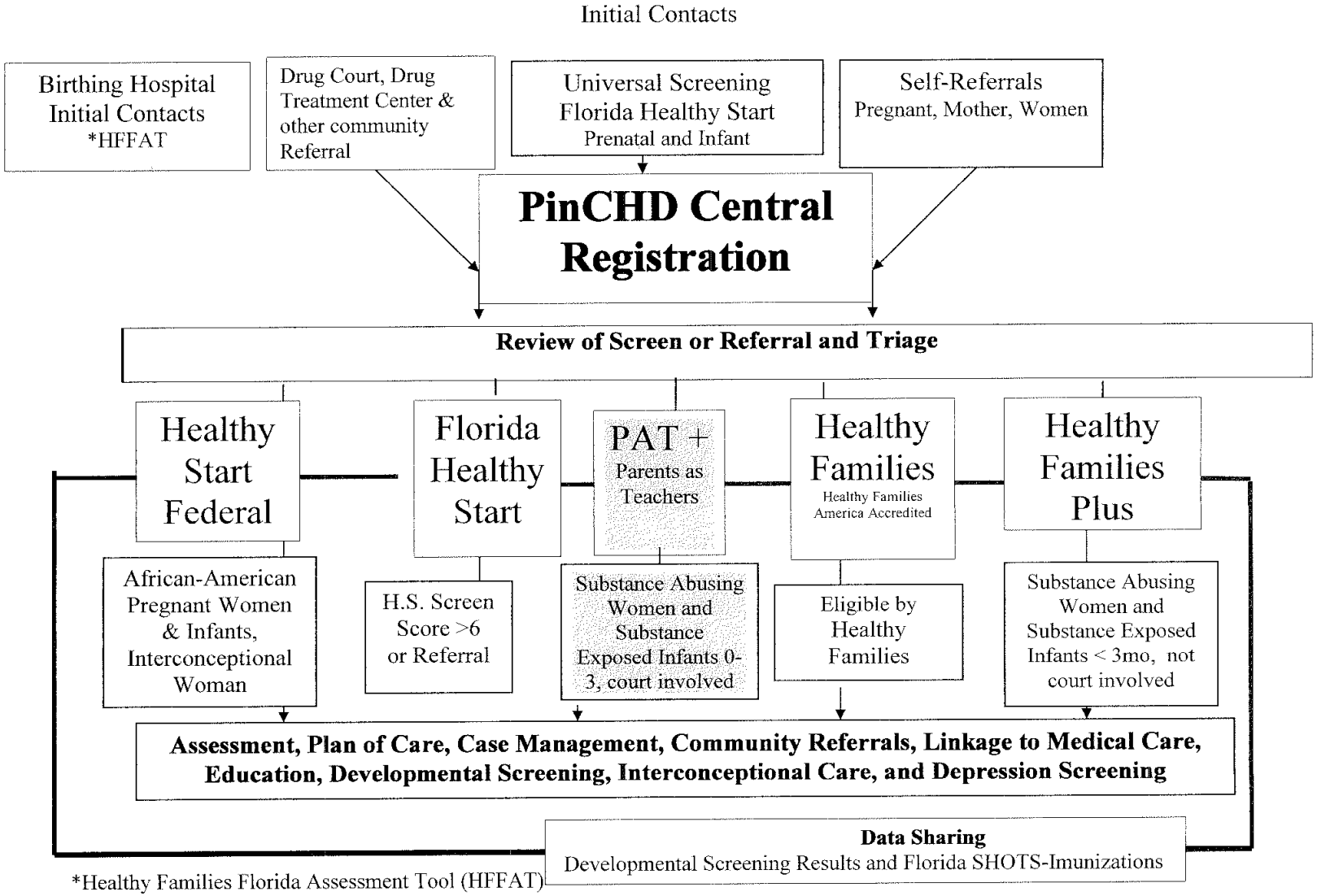
TABLE OF ORGANIZATION



APPENDIX 5

SUPPORTING DOCUMENTS FOR PINELLAS COUNTY

2011 Pinellas County
INTEGRATION WITH LOCAL PERINATAL HEALTH CARE SYSTEM
PINELLAS HOME VISITING SERVICES/ HEALTHY START UMBRELLA



PAT+ Staff List: The chart below depicts the staffing pattern for Pinellas PAT+.

Name	Role/Agency	FTE	Qualifications
Judi Vitucci	Project Director/HSC	.05	PhD, ARNP, 30 years Administrative experience
Astrid Ellis	Operations Manager/HSC	.05	MA, 30 years health care management experience. Expertise in QI, contracts and HS program standards
Bonnie Mettetal	Project Manager/ PAT+ Team Supervisor/ Pinellas County Schools	1.0	BS in elementary education and graduate courses in early childhood; 5 years exp. as PAT supervisor and parent educator; 16 years early childhood educator.
VACANT	Senior Clerk (PinCHD)	1.0	HS. diploma, 1 yr clerical exp. knowledge of standard office practices and HMS data input
Vacant	Parent Educators	2.0	AA or BS in nursing, AA or BA in early childhood or related field; 2 years exp. in the field.
Mia Cachilli	Parent Educator/Pinellas Schools	1.0	BA; 3 years PAT parent educator.
Julia Hamilton	Parent Educator/Pinellas County Schools	1.0	AA elementary ed; 5 years PAT parent educator, 2 years experience with foster teens.
Wanda Trojnar	Parent Educator/Pinellas County Schools	1.0	BS in Sociology, 4 years PAT parent educator.
Marcia Marionette	Evaluator/JWB	.25	Ph.D (ABD) in Sociology, M.A. Criminology. 20 years program evaluation experience with specializations in substance abuse, child maltreatment, and juvenile justice.
Qian Fan	Evaluator/JWB	.25	Ph.D (ABD) Curriculum and Instruction, M.Ed Educational Studies. 6 years evaluation experience with specialization in curriculum content and literacy.

3. Key Staff Experience:

a.. Project Director: **Judi Vitucci, ARNP, PhD** has been the Executive Director of the HSC of Pinellas County, which will serve as the lead agency/grantee, for 6 years. She holds a masters degree in nursing from the University of Florida and a PhD in cultural

anthropology from the University of South Florida. She is a pediatric nurse practitioner with expertise in the 0-3 population. Her research and dissertation was on the topic of maternal substance misuse and substance exposed children 0-3. Dr. Vitucci has successfully administered federal, state and local grants (totaling approximately $16 million) in her 35 years of health care experience. Her education and cross-cultural experience in third world health care settings provides a global perspective to her work. She is a successful grant-writer and grant administrator, an active community partner and effective leader known throughout local and state MCH circles. She will be the final decision maker and provide oversight of the PAT+ program in Pinellas. She will also facilitate the Home Visiting Advisory Committee of the Healthy Start Coalition of Pinellas, Inc. She supervises Nate Forbes and Astrid Ellis who will serve this grant as Finance Manager and Contract/QI Manager respectively.

b. Astrid Ellis, MA is currently the Operations Manager of the Healthy Start Coalition with contract management and quality improvement job functions. She has worked more than 30 years in health care administration with hospitals and clinics where one of the functions was quality improvement programs. She has been writing contracts for services and programs and been responsible for the quality improvement program for the last 12 years. She will provide contract management and quality improvement review for the PAT+ team in this project.

c. **Bonnie Mettetal** is currently the PAT certified Supervisor with Pinellas County Schools PAT team. She has a Bachelor's degree in Elementary Education from the University of South Florida and is certified to teach Primary and Elementary Education. She has 10 years experience as a pre-kindergarten teacher, 4 years experience as a child care provider, 5 years experience as the program manager for Even Start, and 3 years as the family literacy coach for Even Start parent educators. She has taught 40-clock hour child care classes.

d. **Wanda Trojnar** is currently a PAT certified Parent Educator with 4 years of experience. She has a Bachelor's degree in Sociology from Georgia State University.

e. **Mia Cachilli** is currently a PAT certified Parent Educator with 3 years of experience. She has a Bachelor's degree in Management Information Systems from University of

South Florida and three years experience providing parenting for teen parents of Alpha House.

f. **Julia Hamilton** is currently a PAT certified Parent Educator with 5 years of experience. She has an Associate's degree in Exceptional Education from St. Petersburg College and is enrolled in classes to complete her Bachelor's degree. She has 2 years experience working with foster teens.

g. Marcia Marionette is a researcher employed by the JWB Children's Services Council of Pinellas. She is all but dissertation for her Ph.D. in Sociology and has an M.A. degree in Criminology. Her areas of specialization include: program evaluation, social theory (Social Learning Theory), methodology, juvenile delinquency and substance abuse. Marcia's research experience includes evaluation of computer assisted education program for incarcerated juvenile offenders; site coordinator for a nationwide evaluation of a correctional options program; and coordinator for a state.

h. Qian Fan is a Senior Researcher employed by the JWB Children's Services Council in Pinellas. She is expecting her Ph.D. in Curriculum and Instruction from the University of Chicago in 2011. Her M.Ed. is in Educational Studies and her English Education B.A. degree is from Chongqing University in China.

APPENDIX 6

SUPPORTING DOCUMENTS FOR DUVAL COUNTY

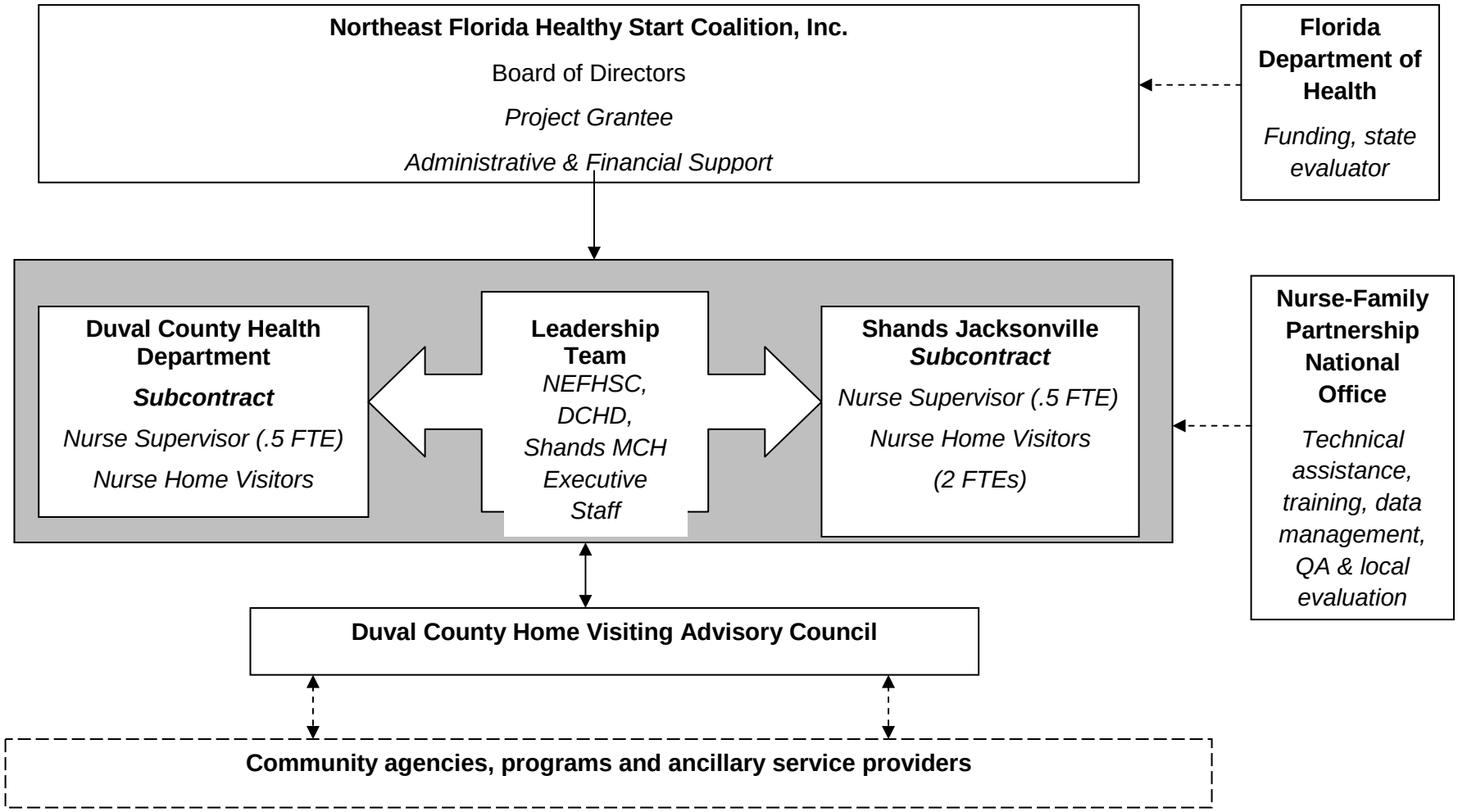
Home Visiting Continuum – Jacksonville-Duval County

Project/ Provider	NEF Healthy Start Coalition *Healthy Start*						Jax Children's Commission *Healthy Families*	Family Support Services	*Early Head Start*
	Magnolia	***Children's Home Society***	***Shands Jax***	***Duval County Health Dept.***	***Azalea***	***Camellia***	***The Bridge, Community Connections***	***Nurse Home Visitor***	***Jax Urban League, Episcopal Children's Services***
Focus	Pre-conceptional	Low-Mod Risk Preg. Women, Infants	Mod-High Risk Prenant. Women, Infants	Mod-High Risk Pregnant Women, Infants	Substance abusing pregnant women	Inter-conceptional (NICU moms)	At-Risk Pregnant women & families	Children in foster care	At-Risk pregnant women & families
Funding	Federal HS	State HS	State HS	State HS	State HS, COJ	MOD	HFF, JCC	DCF	ACF
Eligibility	Age 15-44, high-risk zips, previous poor outcome, risk factors	Score < 6 Healthy Start prenatal, infant screen	Score 6+ Healthy Start prenatal, infant screen	Score 6+ Healthy Start prenatal, infant screen	Score 6+ Healthy Start prenatal screen, SA	Fetal, infant loss, baby in NICU	Score on HS prenatal screen for specific questions	Age 0-5 in foster care	Age 0-3, Poverty level, risk factors
Services	HV, well-woman care, education & awareness, community development	HV, education & support (Level I, II) HS care coordination	HV, education & support (Level III) HS care coordination	HV, education & support (Level II, III) HS care coordination	HV, educ & support (Level III) HS care coordination	HV, assessment, group education & support	HV, assessment, education & support, care cooridination	HV to foster parents, education support, referrals. HV to parents up to 6 months post-reunification	HV, education & support

Intensity	Weekly face-to face visits for 3-6 months initially, transition to monthly based on level, need	Low Risk-Once a trimester; Moderate Risk-Once a month	Level 2 clients once a month; Level 3 clients twice a month	Level 1-once every 3 months; Level 2- once ever month; Level 3 –twice a month	Level 3-twice a month; group activities once a week	1 Face-to-face home based assessment	1 or more visits per week to 1 visit per 3 months (levels).	Based on need	Weekly visits, transition to center-base services
Participants (Annual)	130 (HV only)	2,544	Total 2157 Level 3 - 639	Total 5,748 Level 3 - 493	Total 150 Level 3 - 150	60	935 (2009-10)	TBD	20 New Town 36 other areas
Referral Source(s)	Clinic, HS, community agencies	HS screen	HS screen	HS screen	HS screen, SA providers	NICUs, HS	HS screen	DCF	HS, outreach, community agencies

Proposed Nurse-Family Partnership Program in Duval County

Organization Chart



APPENDIX 7

LETTERS OF APPROVAL

Boston University
School of Medicine

Margot Kaplan-Sanoff, Ed.D.
Associate Professor of Pediatrics
National Program Director, Healthy Steps
Boston University School of Medicine
Boston Medical Center

Vose Building, 4th Floor
72 E Concord Street
Boston, MA 02118-2393
Telephone: 617-414-4767
Fax- 6127-414-7915
sanoff@bu.edu

February 24, 2011

Marianna Tutwiler
Florida Department of Health
Division of Family Health Services
Infant, Maternal, and Reproductive Health

Dear Ms. Tutwiler,

I was delighted to talk with you yesterday about Florida's plan for home visitation models of care. As we discussed, the National Program Office of Healthy Steps for Young Children would be happy to work with any designated community in Florida that chooses to implement Healthy Steps as their evidence based model of care for home visiting.

We already have the following sites operating Healthy Steps in Florida:

Miami Beach Community Health Center,: 2 sites in Miami
Institute for Child and Family Health, Miami
University of Miami Leonard M. Miller School of Medicine: 3 sites in Miami
West coast Access to Children's Care, Sarasota

In addition, we have trained the home visiting staff of the Healthy Start Coalition of Miami-Dade to provide Healthy Steps services to their clients.

Please feel free to contact me if you need any additional information. I look forward to working with you and the communities in Florida.

Sincerely,

Margot Kaplan-Sanoff

HIPPYUSA®

March 23, 2011

Marianna Tutwiler
Florida Department of Health
Division of Family Health Services
Infant, Maternal, and Reproductive Health
4052 Bald Cypress Way, Bin A-13
Tallahassee, FL 32399-1749

Dear Ms. Tutwiler:

Home Instruction for Parents of Preschool Youngsters (HIPPY USA), as licensee of the HIPPY program in the United States, provides this documentation of conditional approval to implement the HIPPY model as part of Florida's Maternal, Infant, and Early Childhood Home Visiting Plan. HIPPY USA has reviewed the proposed Florida state planning process and will grant full approval after reviewing the final plan when it is completed, if HIPPY USA is one of the selected models.

HIPPY USA verifies that it has a system in place to ensure that the model will be implemented as developed, including any proposed adaptations, and will work with the State to make certain the model is implemented with fidelity in all program sites.

In addition, HIPPY USA agrees to participate in the national evaluation of the MIECHV program and any other related Department of Health and Human Services efforts to coordinate evaluation and programmatic technical assistance.

HIPPY USA will contract with sub-grantees in Florida to provide the required authorization for operating a model HIPPY program in the United States.

Should you have any questions, please contact me at 501-537-7727 or llent@hippyusa.org.

Sincerely,

Lia Lent
Interim Executive Director

HIPPY USA 1221 Bishop Street Little Rock, Arkansas 72202 Phone 501.537.7726 Fax 501.537.7716 www.hippyusa.org

Prevent Child Abuse America
228 S. Wabash, 10th Floor
Chicago, IL 60604
312.663.3520
healthyfamiliesamerica.org

June 6, 2011

Ms. Marianna Tutwiler
Florida Department of Health
Division of Family Health Services
Infant, Maternal, and Reproductive Health

Re: Documentation of Approval

Dear Ms. Tutwiler:

This letter is in response to the requirement of the Supplemental Information Request (SIR) from the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program (MIECHV Program) to obtain documentation of approval by the model developer to implement the model as proposed. We have had an opportunity to review the information you provided regarding implementation of the Healthy Families America (HFA) model and any intentions to implement adaptations to the HFA model. **This letter outlines the approval from the HFA national office at Prevent Child Abuse America to use the HFA model in Florida and to enhance the HFA model.**

Currently, HFA is present in 35 states and DC. Healthy Families Florida is unique in our network. It is one of largest and most experienced multi-site accredited systems in our network which currently operates 33 accredited HFA programs through the oversight and support of an accredited Central Administration at the Ounce of Prevention Fund of Florida.
When a state system of sites is accredited through our multi-site process it means there is a Central Administration providing critical functions such as training, quality assurance, technical assistance, fiscal and data management and ongoing evaluation and quality improvement to ensure model fidelity and quality. The Central Administration in Florida provides an infrastructure that allows the HFA National Office to grant certain privileges. These privileges include the following:

1. Any sites currently existing in this multi-site infrastructure are automatically approved from the HFA National Office to receive any funding that would be allocated from the MIEC Home Visiting Program. Included is a listing of sites accountable to the Healthy Families Florida Central Office. The MIECHV funding will be applied to Healthy Families Escambia/Okaloosa located in Escambia County for expansion and enhancement.
2. Healthy Families Florida's Central Administration can affiliate and disaffiliate sites within its state network. Any new Healthy Families lead entities interested in implementing the Healthy Families model where Healthy Families does not currently exist would have to be approved by the Healthy Families Florida Central Administration and would become a part of the current statewide system. These new lead entities would be accountable to the Central Administration. The Central Administration will work with the HFA national office to get final approval of any proposed new lead agencies. According to the Healthy Families Florida policies supported by the National Office, there can only be one lead entity per county or contiguous counties. There are already lead agencies in 55 of Florida's 67 counties that would be eligible for expansion and/or adaptations.
3. Because Healthy Families Florida is an accredited multi-site system, the annual affiliation fee for each project is $1150 versus $1350. Healthy Families Florida Central Administration has its own certified trainers allowing for a cost effective process in training new hires and providing the in-service and ongoing wraparound training required by the HFA national standards.

4.

The SIR allows for the enhancement of the core model. Healthy Families America approves the addition of high-risk specialists to the core staffing in Healthy Families Florida as a means for improving outcomes in families that experience intimate partner violence, mental health issues, and substance abuse. Currently, there are several sites in Florida that have added High Risk Specialists using local cash contributions. HFA national office is in the process of determining how to replicate these services in other sites in the network. The use of high risk specialists in current or new sites in no way alters the core components of the HFA model and is a means of enhancing the likelihood of success with extremely high risk families.

To maintain the fidelity of the model which is required by the federal legislation, it is critical that any Healthy Families Florida site be a part of the current multi-state system administered by the Central Administration. The Departments of Health and Children and Families should collaborate with the Central Administration in the planning, development, approval and implementation of any HFA program in the state. From our perspective, the multi-site infrastructure creates the higher model fidelity and greater outcomes in the most cost effective manner.

We are pleased to grant final approval to implement the HFA model to the Departments of Health and Children and Families. If you would like to discuss this further, I can be reached at kwhitaker@preventchildabuse.org or 520-297-9158. I applaud your commitment to Florida's children and families and look forward to working together in partnership with you.

Sincerely,

Kate Whitaker

Kate Whitaker
Director, HFA Southeastern/Western Region
Prevent Child Abuse America

Cc: Dee Richter
Florida Department of Health

Carol McNally
Healthy Families Florida

Carol Scroggins
Florida Department of Health

Cydney Wessel
Healthy Families America
Prevent Child Abuse America

3/18/11

Annette Phelps, ARNP, MSN
Division of Family Health Services
4025 Bald Cypress Way
Bin A-13
Tallahassee, FL 32399-1723

Dear Ms. Phelps:

Based on the information provided in your state plan, I am pleased to grant approval from the Nurse-Family Partnership National Service Office (NFP NSO), so you may include the Nurse-Family Partnership® Program (NFP) in your revised state plan submission to the Health Resources and Services Administration as part of the Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP). Specifically:

- NFP NSO verifies that we have reviewed Florida's plan as submitted and that it includes the specific elements required in the SIR; and
- NFP NSO is supportive of Florida's participation in the national evaluation and any other related HHS effort to coordinate evaluation and programmatic technical assistance.

Because the Updated State Plan, as required by the SIR, must include additional information on how you will implement the model(s) chosen, it will be important to provide a copy of this to the NFP NSO. We would like to review the following additional details in order to better support the implementation of NFP in your state:

- Identification of the evidence-based home visiting model(s) to be implemented in the State and describe how each model meets the needs of the community(ies) proposed;
- A description of the State's current and prior experience with implementing the model(s) selected, if any, as well as their current capacity to support the model;
- A plan for ensuring implementation, with fidelity to the model, and include a description of the following: the State's overall approach to home visiting quality assurance; the State's approach to program assessment and support of model fidelity; anticipated challenges and risks to maintaining quality and fidelity, and the proposed response to the issues identified;
- Any anticipated challenges and risks of selected program model(s), and the proposed response to the issues identified, and any anticipated technical assistance needs;

As part of our ongoing partnership to support implementation with fidelity to the model, and as part of our required processes, as referenced in the SIR, NFP NSO expects that communities choosing to implement NFP in Florida will enter into a service agreement with NFP NSO and implement NFP in accordance with that agreement. This agreement will outline expectations for NFP Implementing Agencies in communities in the State as well as what supports will be provided by the NFP NSO to include:

- Working directly with the NFP NSO and designated program development staff to implement NFP as designed, including:

1900 Grant Street, Suite 400 | Denver, CO 80203-4304
303.327.4240 | Fax 303.327.4260 | Toll Free 866.864.5226
www.nursefamilypartnership.org

  - Understanding the 18 required model elements;
  - Using NFP-specific implementation planning tools;
  - Accessing NFP support as appropriate with RFP processes and a list of program requirements for inclusion in such processes; and
  - Adhering to NFP agency selection requirements contained in the Implementation Plan and Guidance documents.
- Ensure that every team of nurses employed to deliver NFP will:
  - Receive NFP-specific education as well as expert NFP nursing practice consultation to develop basic competencies in delivering the program model successfully;
  - Receive adequate support and reflective supervision within their agencies;
  - Receive ongoing professional development on topics determined by nursing supervisors to be critical for continued growth. Professional development may be offered within a host agency or through more centralized or shared venues;
  - Engage in individual and collective activities designed to reflect on the team's own practice, review program performance data, and enhance the program's quality and outcomes over time; and
  - Utilize ongoing nurse consultation for ongoing implementation success.
- Participate in all NFP quality initiatives including, but not limited to, research, evaluation, and continuous quality improvement;
- Assure that all organizations implementing NFP use data and reports from our web-based Efforts to Outcomes ™ data system to foster adherence to the model elements in order to achieve outcomes comparable to those achieved in the randomized, controlled trials. This may include creating necessary interfaces between local or state-based data and information systems with our national web-based data system.

This letter also affirms our commitment to work with you as your state implements NFP using designated funds from the MIECHVP. In order to further assist you, we have a set of online resources that can serve as your guide for our continued work together. We are particularly eager to partner with you to consider the kind of support that would enable you to successfully establish NFP in the communities identified in the statewide needs assessment.

Successful replication of Nurse-Family Partnership as an evidence-based home visitation program is dependent on both unwavering commitment to program quality as well as creative and sensitive adaptability to local and state contexts and available resources. We are excited to partner with you to plan how best to support the successful development of Nurse-Family Partnership.

Sincerely,

Kammie Monarch

Kammie Monarch.
Chief Operating Officer
Nurse-Family Partnership National Service Office

1900 Grant Street, Suite 400 | Denver, CO 80203-4304
303.327.4240 | Fax 303.327.4260 | Toll Free 866.864.5226
www.nursefamilypartnership.org

DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Office of Head Start
8th Floor Portals Building
1250 Maryland Avenue, SW
Washington, DC 20024

Marianna Tutwiler
Florida Department of Health
Division of Family Health Services
Infant, Maternal, and Reproductive Health
HSFFM, Bin A-13
4052 Bald Cypress Way
Tallahassee, FL 32399

Dear Ms. Tutwiler,

Thank you for your interest in implementing the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program project in your state, using the Early Head Start (EHS) Home-Based Model.

As Director of the Office of Head Start I am pleased to give you initial approval for implementing the EHS Home Visiting Model. This approval is contingent upon full review of the proposed home visiting implementation plan. The information below is key to implementing the Early Head Start Home-Based Program option in full compliance with all Head Start Program Performance Standards, as they apply to Early Head Start.

Quality services have been the keystone for Early Head Start across its history. In 1994, the Advisory Committee for Services to Infants and Toddlers provided the Federal government with a set of principles to guide the creation of the Early Head Start program. These principles continue to be both a guide and inspiration for quality EHS services. They are designed to nurture healthy attachments between parent and child (and child and caregiver), emphasize a strengths-based, relationship-centered approach to services, and encompass the full range of family needs from pregnancy through a child's third birthday. In short, these principles articulate what a quality EHS program truly delivers to families. They include:

- ***An Emphasis on High Quality*** which recognizes the critical opportunity of EHS programs to positively impact children and families in the early years and beyond.
- ***Prevention and Promotion Activities*** that both promote healthy development and recognize and address atypical development at the earliest stage possible.
- ***Positive Relationships and Continuity*** which honor the critical importance of early attachments on healthy development in early childhood and beyond. The parents are viewed as a child's first, and most important, relationship.
- ***Parent Involvement*** activities that offer parents a meaningful and strategic role in the program's vision, services, and governance.

- ***Inclusion*** strategies that respect the unique developmental trajectories of young children in the context of a typical setting, including children with disabilities.
- ***Cultural competence*** which acknowledges the profound role that culture plays in early development. Programs also recognize the influence of cultural values and beliefs on both staff and families' approaches to child development. Programs work within the context of home languages for all children and families.
- ***Comprehensiveness, Flexibility and Responsiveness*** of services which allow children and families to move across various program options over time, as their life situation demands.
- ***Transition planning*** respects families' need for thought and attention paid to movements across program options and into—and out of—Early Head Start programs.
- ***Collaboration*** is, simply put, central to an Early Head Start program's ability to meet the comprehensive needs of families. Strong partnerships allow programs to expand their services to families with infants and toddlers beyond the door of the program and into the larger community.

The EHS Home Visiting model provides high quality, culturally competent child development and parent support services with an emphasis on the role of the parent as the child's first, and most important relationship. The home-based option is designed for families in which the home is the child's primary learning environment. Participants in the EHS home-based model receive a combination of weekly home visits and regularly scheduled group socializations.

Home visits are conducted with parents or the child's primary caregiver for 90 minutes, generally on a year-round basis. The purpose of the home visit is to support parents in their roles as primary caregivers of their child and to facilitate the child's optimal development within their home environments.

Group socializations are offered twice a month and are designed to support child development by strengthening the parent-child relationship. In the context of a group of families, socialization experiences address child growth and development, parenting, and the parent-child relationship.

For EHS programs enrolling pregnant women, home visits are conducted to ensure pregnant women have access to comprehensive prenatal and postpartum care. A home visit is also used to provide prenatal education on topics such as fetal development, labor and delivery, postpartum recovery (including maternal depression), and the benefits of breastfeeding.

In order to meet the needs of the children and families, a Family Partnership Agreement is created that defines the individualized focus for each enrolled child and family. Through this process, parents are integrally involved in determining the goals and experiences that comprise their child's curriculum, and in identifying goals for themselves that best support their healthy development and self-sufficiency.

The scope of services in the home-based program option is comprehensive, including the following services:

- Developmental screening, ongoing observation and assessment, and curriculum planning

- Medical, dental, and mental health
- Child development and education
- Family partnerships and goal setting
- Community collaborations to meet additional family needs

The relationship of the home visitor with parents or expectant parents is central to effective delivery of this program model. Through ongoing interactions in home visits and socializations, this continuity of the relationship becomes the vehicle through which home visitors support and strengthen parents' or expectant parents' abilities to nurture the healthy development of their children.

For additional information, please contact Angie Godfrey at angie.godfrey@acf.hhs.gov.

Sincerely,

Yvette Sanchez Fuentes
Director

Parents as Teachers

RECEIVED
INFANT,MATERNAL &
MAR 28 2011
REPRODUCTIVE HEALTH

March 21, 2011

Marianna Tutwiler
Florida Department of Health
Division of Family Health Services
4052 Bald Cypress Way
Bin A-13
Tallahassee, FL 232399-1723

Dear Ms. Tutwiler:

Thank you for submitting your State's preliminary plan to implement the Parents as Teachers model under the Maternal, Infant, and Early Childhood Home Visiting Program. In so doing, you agree that those communities/organizations implementing this model will review the Readiness Reflection and meet the Essential Requirements for implementation and will do so with fidelity to the model.

We have reviewed and approved the plan as submitted, but need to hear back from you about your final plans for Parents as Teachers and the identified communities for implementation.

We look forward to a long relationship with Florida as we work together to improve the maternal, infant and early childhood outcomes in your state.

Sincerely,

Susan Stepleton, Ph.D.
President/CEO

Cheryle Dyle-Palmer, M.A.
Chief Operating Officer

UNIVERSITY OF OREGON

March 29, 2011

To: Marianna Tutwiler
Florida Department of Health
Division of Family Health Services
Infant, Maternal, and Reproductive Health
245-4444, Ext. 2973

Dear Ms. Tutwiler,

The Child and Family Center, as the model developer of the Family Check-Up (FCU), provides this documentation of conditional approval to implement the FCU model as part of Florida's Maternal, Infant and Early Childhood Home Visiting Plan. The Child and Family Center will grant full approval upon seeing the implementation plan set forth by the state that includes the Family Check-Up model.

The Child and Family Center verifies that it has a system to ensure that the model will be implemented as developed, including any proposed adaptations, and will work with Florida to make certain the model is implemented with fidelity in all program sites.

In addition, The Child and Family Center agrees to participate in the national evaluation of the MIECHV program and any other related Department of Health and Human Services efforts to coordinate evaluation and programmatic technical assistance.

Should you have any questions, please contact me.

Sincerely,

Beth Stormshak

Beth Stormshak, PhD
Director, Child and Family Center
University of Oregon
(541) 346-3538
bstorm@uoregon.edu

CHILD AND FAMILY CENTER
195 West 12th Avenue · Eugene OR 97401-3408 · (541) 346-4805 · Fax (541) 346-4858

APPENDIX 8

PROGRAM TEAM DOCUMENTS

Title: **Program Administrator**

Positions: 2

Location: One position located at the Florida Deparatment of Health, Division of Family Health Services, Bureau of Family and Community Health, Infant, Maternal and Reproductive Health Unit and one position located at the Florida Department of Children and Families

Job Description: This position facilitates the planning, researching, developing and coordinating of the home visiting grant state plan. Assists with the development of grant required reports; provides technical assistance to ensure compliance with state and federal program laws, rules and regulations and guidelines. Ensures appropriate coordination with other sections of the Department of Health, Department of Health and Human Services, other states, and other state agencies as well as the public. Serve as contract manager as required by Section 287.057(15), Florida Statutes.

Duties and responsibilities: Act as the liaison to DCF in the planning and development of the MIEC Home Visiting Program; facilitate and participate in the planning and development of the Maternal, Infant and Early Childhood (MIEC) Home Visiting program development; serve as a leader on interdepartmental and intradepartmental workgroups and meetings and participate in work efforts related to those workgroups and meetings; supervise the procurement, contract and budget management and overall daily management of the MIEC Home Visiting grant and program; and provide on-site management of program staff to ensure that the program is implemented as outlined by the grant guidance and to ensure the provision of efficient and effective MIEC Home Visiting health services.

Qualifications for position: A bachelor's degree from an accredited college or university and three years of professional experience in systems analysis, management analysis, program planning and development, public health, nursing, social work, program research, program evaluation, or administrative work. A master's degree from an accredited college or university can substitute for one year of the required experience. Professional or nonprofessional experience as described above can substitute on a year-for-year basis for the required college education. Must have or obtain Department of Health contract manager certification as required by Section 287.057(15), Florida Statutes.

Skills and knowledge required: Knowledge of the methods of data collection and analysis; ability to collect, evaluate and analyze data to develop alternative recommendations, solve problems, document work flow and other activities relating to the improvement of operational and management practices; ability to organize data into logical format for presentation in reports, documents and other written materials; ability to conduct fact-finding research; ability to utilize problem-solving techniques; ability to work independently; ability to understand and apply applicable rules, regulations, policies and procedures relating to operational and management analysis activities; ability to plan, organize and coordinate work assignments; ability to communicate effectively verbally and in writing; ability to plan and develop programs or program components; knowledge of the principles and practices of the public health care delivery system, administration and planning; ability to problem solve, plan, organize and direct service program activities; ability to maintain effective working relationships and ability to travel within and outside the State of Florida.

Title: **Medical Healthcare Analyst**
Positions: 2
Location: One position at the Florida Department of Health, Division of Family Health Services, Bureau of Family and Community Health, Infant, Maternal and Reproductive Health Unit and one position at the Florida Department of Children and Families

Job Description: This position provides technical assistance and guidance to unit program staff, external stakeholders and contract providers regarding the planning, development, and implementation of the Maternal, Infant, and Early Childhood Home Visiting state plan. This position serves as a contract manager. This position requires the ability to work independently without close supervision.

Duties and responsibilities: Development of policies, protocols, standards, and guidelines and any other documents necessary for the administration and implementation of the MIEC Home Visiting Program services.

Reviews, on a regular basis, maternal, infant, early childhood and at risk families health and environmental issues and other health related materials that impact policy and program development. Responds to requests for information regarding the operation of the Maternal, Infant and Early Childhood Home Visiting Program.

On site monitoring of processes and activities related to the Quality Assurance reviews of the Maternal, Infant and Early Childhood (MIEC) Home Visiting program contracted providers. Coordinates and assures the provision of accurate and up to date technical assistance and monitoring of services for compliance with state and federal guidelines.

Ensures that processes are in place to analyze data and trends related to the health of the maternal, infant, children and at risk families who receive services through the MIEC Home Visiting program. Recommends solutions that could improve services and systems throughout the state.

Develops and coordinates processes to assure high quality training on infant, maternal, children and at risk families. Assists and facilitates training programs, workshops, or seminars to build capacity and integrate a variety of topics and services affecting maternal, infants, children and at risk families.

Provides consultation and technical assistance as requested in matters related to the MIEC Home Visiting Program, public health and/or other areas as assigned responsibility and as requested.

Leads and participates on interdepartmental and intradepartmental workgroups and meetings and participates in work efforts related to those workgroups and meetings. Coordinates or facilitates planning and development of new and or expanded infant, child, maternal, and at risk families initiatives, providing technical assistance and serving as a liaison with other agencies and organizations.

Performs other duties and responsibilities as may be assigned or required, utilizing knowledge of the basic principles and practices of public health.

Title: **Medical Healthcare Analyst**
Positions: 2
Location: One position at the Florida Department of Health, Division of Family Health Services, Bureau of Family and Community Health, Infant, Maternal and Reproductive Health Unit and one position at the Florida Department of Children and Families

Job Description: This position provides technical assistance and guidance to unit program staff, external stakeholders and contract providers regarding the planning, development, and implementation of the Maternal, Infant, and Early Childhood Home Visiting state plan. This position serves as a contract manager. This position requires the ability to work independently without close supervision.

Duties and responsibilities: Development of policies, protocols, standards, and guidelines and any other documents necessary for the administration and implementation of the MIEC Home Visiting Program services.

Reviews, on a regular basis, maternal, infant, early childhood and at risk families health and environmental issues and other health related materials that impact policy and program development. Responds to requests for information regarding the operation of the Maternal, Infant and Early Childhood Home Visiting Program.

On site monitoring of processes and activities related to the Quality Assurance reviews of the Maternal, Infant and Early Childhood (MIEC) Home Visiting program contracted providers. Coordinates and assures the provision of accurate and up to date technical assistance and monitoring of services for compliance with state and federal guidelines.

Ensures that processes are in place to analyze data and trends related to the health of the maternal, infant, children and at risk families who receive services through the MIEC Home Visiting program. Recommends solutions that could improve services and systems throughout the state.

Develops and coordinates processes to assure high quality training on infant, maternal, children and at risk families. Assists and facilitates training programs, workshops, or seminars to build capacity and integrate a variety of topics and services affecting maternal, infants, children and at risk families.

Provides consultation and technical assistance as requested in matters related to the MIEC Home Visiting Program, public health and/or other areas as assigned responsibility and as requested.

Leads and participates on interdepartmental and intradepartmental workgroups and meetings and participates in work efforts related to those workgroups and meetings. Coordinates or facilitates planning and development of new and or expanded infant, child, maternal, and at risk families initiatives, providing technical assistance and serving as a liaison with other agencies and organizations.

Performs other duties and responsibilities as may be assigned or required, utilizing knowledge of the basic principles and practices of public health.

Title: Support Staff

Positions: 1

Location: Florida Department of Health, Division of Family Health Services, Bureau of Family and Community Health, Infant, Maternal and Reproductive Health Unit

Job Description: This position is responsible for assisting the Program Administrator and staff with the administrative functions as they relate to the Maternal, Infant and Early Childhood Home Visiting program.

Duties and responsibilities: Performs administrative functions including assisting with grant application activities, schedule meetings, prepare correspondence (for routing or e-mail), develop meeting minutes, develop and maintain records, reports, personnel actions and other related materials. Proofread, edit and format written reports; processes reports for routing of approvals; processes incoming and outgoing mail and distributes appropriately and makes copies of correspondence, maintains files and other documents as needed. Assists with travel arrangements for IMRH staff and processes travel authorizations and reimbursement vouchers within required timeframes. Develops, maintains, and updates directory of frequently used hotels, point of contacts, pricing and other pertinent information as requested. Maintains office records and files for travel vouchers and reimbursements. Responds to assignments as requested. Collaborates with staff from various programs to assist with their projects/assignments as needed. Trains other support staff as needed and rotates the back-up support function with other support staff. Serves as a resource person for other support staff. Performs other duties and responsibilities as assigned or required by the bureau and division.

Qualifications for position: Three years of secretarial or office clerical work experience; or possession of a Certified Professional Secretary Certificate. College education from an accredited institution can substitute for two years of the required work experience. Vocational/technical training or a high school diploma or its equivalent can substitute for one year of the required work experience.

Skills and knowledge required: Ability to collect, compile and organize files and records; knowledge of correct spelling, punctuation, and grammar; ability to work with others and meet and deal with internal and external customers; ability to work under pressure; ability to work independently; ability to prioritize, organize, and schedule work assignments; ability to handle a multi-line telephone system; knowledge of and ability to use Microsoft Word, Excel and Outlook programs.

CURRICULUM VITAE
ANNETTE PHELPS, A.R.N.P., M.S.N.

EDUCATION

University of Florida, College of Nursing, Gainesville, Florida.
Bachelor of Science in Nursing with high honors, March 1974.
Certificate as Nurse Practitioner in Adult Care, August 1976.
Master of Science in Nursing, December 1981.
University of South Florida, College of Public Health, Tampa, Florida.
Certificate Public Health Leadership Institute, 1999.

WORK EXPERIENCE

Florida Department of Health, State Health Office, Division Director, Family Health Services 3/1/02 to present, Bureau Chief of Family and Community Health, Tallahassee, Florida, 6/12/98 to 3/1/02. (Acting Director, Division of Family Health Services, 6/1/01 to 3/1/02) Maternal and Child Health, Executive Community Health Nursing Director, 11/24/89 to 6/12/98.

Florida Department of Health and Rehabilitative Services Okaloosa County Public Health Unit, Fort Walton Beach, Florida, Public Health Nurse Specialist, 1981-1982; Community Health Nursing Supervisor, 1982-1985; Senior Community Health Nursing Supervisor, 1985-1989.

Adjunct Faculty, University of West Florida, Department of Nursing, 1983-1989.

Veterans Administration Medical Center, Gainesville, Florida, Primary Care Nurse Practitioner, Evaluation Clinic, 1978-1980.

Student Health Service, University of Florida, Gainesville, Florida, Registered Nurse Clinical Associate, 1976-1978.

Shands Teaching Hospital, Gainesville, Florida, Surgical Intensive Care Unit, Registered Teaching Nurse, 1974-1975; Assistant Head Nurse, 1975-1976.

Sigma Scientific, Inc., Gainesville, Florida, Assistant Supervisor, Printing Department, 1971-1972.

ACTIVITIES AND HONORS

Professional:

MCH Journal peer reviewer 2006 to present.

National Public Health Leadership Institute Scholar, Class 12, 2002-2004, team implemented public health nurse mentor pilot program.

Appointed to the National Consortium for the Fetal and Infant Mortality Review (FIMR) Program 2002 (continuing to present), serve on National Conference planning committee, and lead the training track for basic FIMR program implementation.

Co-chair of the Florida Depression Screening Work Group for Action Learning in partnership with the American College of Obstetrics and Gynecology—2002-2003.

Florida Public Health Association, Excellence in Maternal and Child Health Award, 2002.

Southeast Regional Maternal and Child Health Award for Leadership 2001.

Member, Association of Maternal and Child Health Programs; 2001 to present—Past Chair, Governance Committee (Board Position); Member At-Large, Board of Directors 2005-2012 term. Have represented the association on a variety of national task forces and advisory groups.

Member, Advisory Board Florida Public Health Leadership Institute, 2001.

Member, Florida Public Health Association, past member American Public Health Association, Co-Chair, FPHA Maternal and Child Health Section, 2000-2001. Past Chair Nursing Section and Past member, Southern Health Association.

Sigma Theta Tau – National Nursing Honor Society, Alpha Theta Chapter, Past President, Vice-President, Secretary, Publicity and Program Chairperson.

American Nurses Association, Florida Nurses Association, District 24.

Listed in inaugural edition of Who's Who in American Nursing, 1985.

Florida Blue Key, Honor Fraternity, University of Florida.

Phi Kappa Phi, Honor Society, University of Florida.

University of Florida Presidential Recognition Award, 1980.

Certified as Adult Nurse Practitioner by ANA exam 1980 to 1985 when I expanded my practice to Family and Community Nursing.

Outstanding Young Women of America, listed in biographical directory, 1981.

Established a nurse-operated family health clinic in student housing while in graduate school. The clinic was utilized by other graduate students for clinical experience.

Thesis, An Assessment of the Health Care Needs of University Student Families, 1981.

Co-developed the District 1 HRS Orientation to Public Health Nursing Course, 1985.

Member, HRS State Pharmacy Committee, 1988 to 1990.

Represent the Florida Department of Health on a variety of statewide advisory and leadership boards including past member of the Partnership for School Readiness and currently sit on Healthy Families Florida Advisory Committee (since 2002).

Have been instrumental in the development and delivery of professional education programs and innovative programs including the Fetal and Infant Mortality Review and the Pregnancy Associated Mortality Review Programs. Facilitated invitational meeting on Safe Motherhood at the request of the CDC, HRSA , ACOG, and AMCHP partnership 2003.

Have held a variety of positions and roles in multi-agency and public/private working groups ranging from core contract development for Medicaid Managed Care to development of interagency agreements.

Have served on a variety of state task forces and pilot projects, including: Operations and Performance Excellence Team, Chair Prenatal Care Task Force, Co-Chair School Nurse Training Work Group, Clinical Records and Forms Committee, Professional Staff Council, Services Council, Patient Flow Analysis in Public Health Unit, Records Management, Positive Parenting, Public Health Nursing Orientation, and a variety of statewide trainings for Public Health Nurses.

Managed the Florida Board of Nursing Provider Number of the Okaloosa County Public Health Unit from application to planning and providing offerings through 1989.

Member, Advisory Panel for Low Risk Pregnancy, District 1, Florida Department of HRS, 1983 to 1988.

Presentations at the state and national levels, including: CDC/AGOG Maternal Mortality Committee, Federal Technical Assistance Teams, National Fetal and Infant Mortality Program, Association of Maternal and Child Health Programs, National Association of Data Professionals, American College of Nurse Midwives, and American and Florida Public Health Associations.

Community:

Member, Board of Directors, Fort Walton Beach Chapter American Heart

Association, 1987-1989. School Site Chairman, 1987-1989. Member, Florida Affiliate Statewide School Site Committee, 1990 to 1995.

Tallahassee Heights United Methodist Church, Member, Administrative Council, 1998 – 2001.

Junior League of Fort Walton Beach, 1983-1987.

Girl Scouts of America, adult member and assistant leader, 1985 to 1996.

American Red Cross CPR Instructor, 1986 to 1990.

Volunteer services with a variety of local groups including Habitat for Humanity, American Cancer Society, SHARE, PTA over a number of years.

Member, School Advisory Committee Hartsfield Elementary School
95 – 96 and 94 – 95 and Cobb Middle School 96 – 97, Tallahassee, Florida.

Past Member Apalachee Bay Yacht Club, Scribe 2004.

Member Auxillary of the Apalachee Bay Volunteer Fire Department, Shell Point, 2003 to present.

PUBLICATIONS

"Florida's Pregnancy Associated Mortality Review: A Maternal Mortality Review Process" S. Bulecza, A. Phelps, R. Brooks in OB/GYN Today, Florida ACOG Journal, Winter 2001.

"Rapid Assessment of the Needs and Health Status in Santa Rosa and Escambia Counites, Florida, after Hurricane Ivan, September 2004" T. Bayleyegn, MD; A. Wolkin, MSPH; K. Oberst, RN, MS, PEM; S. Young, MS< MPH; C. Ruben, DVM, MPH; and D. Batts, MD: Disaster Management & Response Journal, January 2006, Volume 4, Number 1.

SELECTED PRESENTATIONS

Southeast Regional Conference on Child Fatalities May 15-17, 2000—"FIMR and CDR: Opportunities for Local Collaboration", Annette Phelps.

National Fetal and Infant Mortality Conference for State Coordinators July 12 and 13, 2000—"Helping Local FIMR Programs Take Recommendations to Action and Impact Service Delivery Systems: Tips from Experience", Annette Phelps, Sean Casey, Elin Holgren; "The Unique Contributions of FIMR, State Title V Needs Assessment", Annette Phelps; and "Coordinating FIMR, CFR, and/or MMR: The Florida and Soutn Carollina Models", Annette Phelps and Elin Holgren.

4th National FIMR Conference, August 2-4, 2001—"Basic Workshop: ABCs of FIMR ", Annette Phelps, Dani Noell, Dan Timmel; and CDC's Maternal Mortality Efforts and Florida's Pregnancy Associated Mortality Review.

CAREER INTERESTS

Family and Community Health
Nursing Consultation and Technical Assistance
Public Health Nursing Administration
Teaching
Public Health Research and Implementation of Research Findings

MARIANNA TUTWILER

EDUCATION

INSTITUTION	DEGREE AND MAJOR	YEAR GRANTED
Florida State University	MPA and MSW	1992
University of Florida	B.S.	1986

EMPLOYMENT

INSTITUTION	POSITION/TITLE	YEARS
Florida Department of Health	Governmental Analyst II *Lead analyst in guiding the Division of Family Health Services in writing a state plan for implementing a comprehensive home visiting program for at risk mothers and children.*	2010 - present
University of South Florida *Lawton and Rhea Chiles Center*	Associate in Research/Program Director *Procured and managed contracts with state agencies specializing in providing technical assistance, training, and process evaluation activities to programs serving vulnerable populations. Supervised staff serving on multiple contracts.*	2005 - 2010
University of South Florida *Lawton and Rhea Chiles Center*	Project Coordinator *Coordinated implementation of Florida KidCare outreach activities to refugee populations throughout Florida, including orchestration of translating multiple documents into six languages, developing and conducting a training curriculum statewide*	2000 - 2005
Florida Legislature	Legislative Analyst *Lead analyst on researching policies and practices related to truancy in Florida. Worked with the Departments of Education and Juvenile Justice and the Legislature to improve educational services to youth committed to institutions for long periods of time.*	1997-2000
Florida State University	Adjunct Professor	1996 -1997
Florida A & M University	Adjunct Professor	1995 -1997
University of West Florida	Program Coordinator *Responsible for the Juvenile Alternative Services Program; judicially held first-time juvenile offenders accountable for their actions. Supervised staff in 14 counties*	1990-1995

TEACHING

UNDERGRADUATE COURSES:

Introduction to Social Welfare

Community Organizing

Social Policy and Programs

Social Work and Chemical Dependency

Youth and Violence

PAPERS AND PRESENTATIONS

Papers

Refugee Health Status and Healthcare Utilization Report

June 2010

Refugee Health Status and Healthcare Utilization Report

October 2009

Medicaid Comprehensive Behavioral Health Assessment Evaluation

June 2008

Duval County Refugee Health Care Utilization Process

June 2007

Effective Florida KidCare Outreach Strategies for Refugee, Entrant, and Asylee Families

February 2003

Hispanic Outreach Program Guide – Child Health Outreach Program

May 2002

Florida's Response to Truancy: A Review of Coordinated Efforts at Truancy Centers in Juvenile Assessment Centers

May 1998

Truancy: Florida's Response to Troubled Youth

October 1997

Presentations

Department of Children and Families, Dependency Summit, September 2008

Society for Applied Anthropology, 67th Annual Meeting, March 2007

Annual Medicaid Conference, July 2007

Florida Network of Youth and Family Services

Florida Network Conference and Truancy Symposium, July 1998

1998 DJJ Prevention Conference, August 1998

Florida Association of School Social Workers and Department of Education

Fifth Annual Truancy Symposium, December 1997

COMMUNITY SERVICE AND ACTIVITIES

Co-Owner of Namaste Yoga Studio

Volunteer in various capacities related to my children's sports and club activities

Javier Vazquez

Education

Florida State University, College of Social Sciences and Public Policy — **Tallahassee, FL**
Master of Public Health — May 2010

Florida State University, College of Human Sciences — **Tallahassee, FL**
Bachelor of Science in Exercise Science — August 2008
Honors: Dean's List, Kappa Omicron Nu National Honor Society, Florida Bright Futures Scholarship

Experience

Florida Department of Health, Division of Family Health Services — **Tallahassee, FL**
Medical Healthcare Program Analyst — January 2011 - Present
Assist in the coordination of the research, planning, development, and implementation of Florida's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program; Work as the liaison and contract manager for the MIECHV Program's contracted providers; Provide consultation and technical assistance to program staff, external stakeholders, and contracted providers in the preparation of state plans, grant applications, and contracts; Ensure overall program compliance with federal and state financial and administrative requirements; Assist with the development of grant required reports; Coordinate federal grant requirements with state public health goals and objectives to ensure consistency in purpose and efficient and effective provision of services; Develop, track, and provide various reports.

Florida Department of Health, Office of Minority Health — **Tallahassee, FL**
Staff Assistant — July - December 2010
Served as contract manager to Closing the Gap immunization contracts and additional funded community projects; Monitored records, compiled data, and prepared reports to illustrate the status, progress, and performance of funded programs for the Deputy Secretary for Health and the Closing the Gap Advisory Committee.

University of South Florida, College of Public Health, Lawton and Rhea Chiles Center — **Tallahassee, FL**
Program Analyst — July 2009 - September 2010
Analyzed data and prepared a subsequent report identifying best practices in the provision of domestic health assessments and Medicaid enrollment for the state's arrival population; Examined data and prepared a subsequent report identifying the state's arrival population's health and health care utilization; Prepared a report comparing the health and health care utilization of two arrival cohorts; Assisted in the development of the MIECHV Needs Assessment.

Florida State University, College of Medicine, Center for Rural Health Research and Policy — **Tallahassee, FL**
Graduate Research Assistant — January 2009 - November 2010
Developed health and literacy promoting theory-based fotonovelas for use in adult literacy programs; Field-tested materials with a migrant Hispanic population residing in a rural geographic area; Prepared a final report of activities, experiences, results, and recommendations.

Refuge House, Inc. — **Tallahassee, FL**
Children's Advocate — March 2007 - July 2008
Provided crisis intervention, counseling, and advocacy to victims of domestic violence, sexual violence, and human trafficking; Organized and facilitated support groups for clients on safety planning, non-violent interactions, social skills, and anger management; Designed and implemented specialized lesson plans to promote early childhood development for children participating in the child care and pre-k programs; Linked clients with appropriate resources.

Relevant Skills/Training

Florida Department of Health Certificate of Completion in Contract Payment Issues; Programmatic Monitoring; Contract Negotiation Strategies and Techniques; Basic Contract Management Training; Evidence-Based Public Health Course: A Course in Chronic Disease Prevention

Proficient in Microsoft Word, Excel, PowerPoint, and Outlook; Working knowledge of R, GIS, AutoCAD, and Microsoft Visio

Fluent in Spanish

References Available Upon Request

PATRICIA HARRELL
Phone: 850-245-4465
Trish_Harrell@doh.state.fl.us

4025 BALD CYPRESS WAY A13
Tallahassee Fl 32399

Objective

My objective is to gain a working knowledge in business practices and gain the experience necessary to obtain my career goal.

Employment History

Staff Assistant 05/2011- Present	Supervisor: Carol Scoggins Florida Department of Health, Tallahassee FL, (850) 245-4465 Provide direct staff support to professional staff, perform administrative functions, schedule meetings, preparing correspondence (for routing or e-mail), developing meeting minutes, developing and maintaining records, proofread, edit and format written reports, processes incoming and outgoing mail, making copies of correspondence, maintain files and other documents as needed.
Senior Clerk 07/2010 - 04/2011	Supervisor: Cecil Garrett Florida Dept. of Revenue, Tallahassee FL, (850) 717-6400 Processing mail, filing, indexing, data entry, maintaining spreadsheets, archival process, document preparation for scanning, and prepping new hire packets.
Transaction Processor 08/2008 - 01/2010	Supervisor: Walter Hicks (Facilities Services Manager) ACS Health Administration, Inc Tallahassee, FL (850) 201-1337 Processing mail, data entry.
Receptionist 03/2008 - 08/2008	Supervisor: Veronica Harris (General Manager) Harris Auto & Truck Solutions Tallahassee, FL (850) 421-7700 Answering phones, filing, filling out work orders, and data entry.
Cashier 09/2007 - 03/2008	Supervisor: Chuck (General Manager) Harvey's Supermarket Tallahassee, FL (850) 575-8905 Ringing up customers, bagging groceries, stocking, and cleaning.
Cashier 01/2007 - 05/2007	Supervisor: Don (General Manager) Chick Fil A, Tallahassee, FL (850)385-0599 Placing customer's orders, ringing them up, cleaning, bagging food, and making milkshakes.
Hostess 07/2006 - 12/2006	Supervisor: Rush (Manager) Crystal River Seafood Tallahassee, FL (850) 575-4418 Seated customers, set tables, helped waiter, brought out drinks.
Receptionist 01/2006 - 06/2006	Supervisor: Melody Byrd (Office Manager) Walker Body Shop Tallahassee, FL (850) 576-7159 Answering phones, filing, filling out work orders, and data entry.

Education History

Completion Date	05/31/2008
Issuing Institution	Amos P Godby High School
Degree Received	High School Diploma
Course of Study	General High School Education

Proficiencies

- Cash handling and balancing a cash drawer
- Extensive computer skills including Microsoft Office and data entry systems
- Excellent customer service skills
- Receptionist and filing skills

Interests

My interests include fitness, arts and crafts, baking, and outdoor activities.

BUDGET INFORMATION - ..on-Construction Programs

OMB Approval N 48-0044

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Home Visiting	93.505	$ 3,405,228.00	$	$	$	$ 3,405,228.00
2.						0.00
3.						0.00
4.						0.00
5. Totals		$ 3,405,228.00	$ 0.00	$ 0.00	$ 0.00	$ 3,405,228.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)		Total (5)
a. Personnel	$ 38,400.00	$	$	$	$ 38,400.00
b. Fringe Benefits	557.00				557.00
c. Travel	6,713.00				6,713.00
d. Equipment	0.00				0.00
e. Supplies	3,328.00				3,328.00
f. Contractual	3,288,587.00				3,288,587.00
g. Construction					0.00
h. Other	57,904.00				57,904.00
i. Total Direct Charges *(sum of 6a-6h)*	3,395,489.00	0.00	0.00	0.00	3,395,489.00
j. Indirect Charges	9,739.00				9,739.00
k. TOTALS *(sum of 6i and 6j)*	$ 3,405,228.00	$ 0.00	$ 0.00	$ 0.00	$ 3,405,228.00
7. Program Income	$	$	$	$	$ 0.00

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SECTION C - NON-FEDERAL RESOURCES				
(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	$	$	$	$ 0.00
9.				0.00
10.				0.00
11.				0.00
12. TOTAL *(sum of lines 8-11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 3,405,228.00	$ 851,307.00	$ 851,307.00	$ 851,307.00	$ 851,307.00
14. Non-Federal	0.00				
15. TOTAL *(sum of lines 13 and 14)*	$ 3,405,228.00	$ 851,307.00	$ 851,307.00	$ 851,307.00	$ 851,307.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT				
(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION F - OTHER BUDGET INFORMATION	
21. Direct Charges:	22. Indirect Charges:
23. Remarks:	

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REVISED BUDGET

Budget Period 07/15/10 – 09/30/12

A. PERSONNEL **TOTAL $38,400**

Position Title Employee Name	Monthly Salary	% of Time	No. of Months	$ Amount
Systems Analyst I *FDOH Temporary OPS Position	$4,800	100%	8 months	$38,400

See Budget Justification, Section A, for Personnel calculations listed above.

B. FRINGE BENEFITS **TOTAL $557**

Systems Analyst I *FDOH Temporary OPS Position 1.45% x $38,400	$557

C. TRAVEL **TOTAL $6,713**

1. In-state travel for On-Site Contract Monitoring

Travel for On-Site Contract Monitoring	
5 trips x 1 person x $400 airfare	$2,000
5 trips x 2 days ground transport x $30/day	$300
5 trips x vicinity fuel cost x $25	$125
5 trips x 2 nights lodging x $150 lodging	$1,500
5 trips x 2 days meals x $36/day	$360
5 trips x 1 day per diem x $80/day	$400
5 trips x 2 days parking x $8/day	$80
SUBTOTAL	*$4,765*

2. Out of state face-to-face Grant Required Federally Initiated Grantee Meeting

Grant Required Federally Initiated Grantee Meeting	
1 trip x 2 persons x $450 airfare	$900
1 trip x 2 persons x 2 nights lodging x $150 lodging	$600
1 trip x 2 persons x 2 days meals x $36/day	$288
1 trip x 2 persons x 1 day per diem x $80/day	$160
SUBTOTAL	*$1,948*

See Budget Justification, Section C, Numbers 1-2 for travel listed above.

D. EQUIPMENT **TOTAL $0**

E. SUPPLIES **TOTAL $3,328**

1. General Office Supplies for 7 Personnel - $32.00 per month for each employee

Systems Analyst I = *(1 Position x 8 months) x $32.00*	*$256*
Program Administrator = *(2 positions x 15 months) x $32.00*	*$960*
Community Health Nursing Consultant = *(1 Position x 15 months) x $32.00*	*$480*
Medical Health Care Program Analyst = *(1 Position x 20 months) x $32.00*	*$640*
Medical Health Care Program Analyst = *(1 Position x 15 months) x $32.00*	*$480*

Staff Assistant = *(1 Position x 16 months) x $32.00* *$512*

See Budget Justification, Section E, Number 1 for supplies listed above.

F. CONTRACTUAL **TOTAL $3,288,587**

1.	Contract with an entity to plan, research, develop, review, coordinate, and compile the Maternal, Infant and Early Childhood (MIEC) Home Visiting Needs Assessment report	$32,787
2.	Contract with an entity for the final grant submission	$15,000
3.	Contract with an entity for the evaluation	$367,207
4.	Contract with entities to implement the program models	$2,327,662
5.	Contract with entities to review and evaluate the RFA's	$3,000
6.	Contracted personnel and fringe benefits (See breakdown below)	$542,931

Position Title Employee Name	Monthly Salary	% of Time	No. of Months	$ Amount
Program Administrator *TBD*	*$4,333*	*100%*	*15 months*	*$64,995*
Program Administrator **Depart. of Children & Families (DCF)* *TBD*	*$4,333*	*100%*	*15 months*	*$64,995*
Community Health Nursing Consultant *TBD*	*$3,999*	*100%*	*15 months*	*$59,985*
Medical Health Care Program Analyst *Javier Vazquez*	*$3,412*	*100%*	*20 months*	*$68,240*
Medical Health Care Program Analyst **Depart. of Children & Families (DCF)* *TBD*	*$3,412*	*100%*	*15 months*	*$51,180*
Staff Assistant *Patricia Harrell*	*$1,957*	*100%*	*16 months*	*$31,312*

Program Administrator

Salary (2 positions x 15 months)	*$129,990*
Mandatory Benefits calculated at 15% of salary	$19,499
Benefits package calculated at the family rate of $2,409 monthly x 15 months	$36,135
Administrative Fee calculated at 7% of salary +mandatory benefits + benefits	$12,994

Community Health Nursing Consultant

Salary (1 Position x 15 months)	*$59,985*
Mandatory Benefits calculated at 15% of salary	$8,998
Benefits package calculated at the family rate of $1,204 monthly x 15 months	$18,060
Administrative Fee calculated at 7% of salary +mandatory benefits + benefits	$6,093

Medical Health Care Program Analyst	
Salary (1 Position x 20 months)	*$68,240*
Mandatory Benefits calculated at 15% of salary	$10,236
Benefits package calculated at the family rate of $1,204 x 20 months	$24,080
Administrative Fee calculated at 7% of salary +mandatory benefits + benefits	$7,179
Medical Health Care Program Analyst	
Salary (1 Position x 15 months)	*$51,180*
Mandatory Benefits calculated at 15% of salary	$7,677
Benefits package calculated at the family rate of $1,204 x 15 months	$18,060
Administrative Fee calculated at 7% of salary +mandatory benefits + benefits	$5,384
Staff Assistant	
Salary (1 Position x 16 months)	*$31,312*
Mandatory Benefits calculated at 15% of salary	$4,697
Benefits package calculated at the family rate of $1,204 monthly x 16 months	$19,264
Administrative Fee calculated at 7% of salary +mandatory benefits + benefits	$3,869

See Budget Justification, Section F, Numbers 1-6 for contractual items listed above.

G. OTHER	**TOTAL $57,904**
1. Telephone $758/year 6 professional staff (monthly rate $63 x 80 months) and $412/year x 1 staff support (monthly rate $34 x 16 months)	$5,584
2. Postage $132/year 6 professional staff (monthly rate $11 x 80) and $100/year 1 staff support (monthly rate 8 x 16 months)	$1,008
3. DOH/DCF printing/reproduction $121/year 6 professional staff and 1 staff support (monthly rate $10 x 96 months)	$960
4. Repair/Maintenance $121/year 6 professional staff (monthly rate $10 x 80 months)	$800
5. Office space $3,866/year x 6 professional staff (monthly rate $322 x 80 months) and $3,007/year 1 staff support (monthly rate $251 x 16 months)	$29,776
6. Technology equipment and assessment $2,472 x 6 professional staff and 1 staff support (monthly rate $206 x 96 months)	$19,776

See Budget Justification, Section G, Numbers 1-6, for items listed above.

H. TOTAL DIRECT COST	**TOTAL $3,395,628**
A. Personnel	$38,400
B. Fringe	$557
C. Travel	$6,713
D. Equipment	$0
E. Supplies	$3,328
F. Contractual	$3,288,587
G. Other	$57,904

I. INDIRECT COST		**TOTAL $9,739**
Personnel (Salary for Systems Analyst I Temporary OPS)	$38,400	
Fringe	557	
Subtotal	$38,957	
DOH Approved Indirect Cost Rate	x 25%	
Total Indirect Cost	$9,739	

Indirect Cost rates are negotiated between the Florida Department of Health and the Department of Health and Human Services – Cost Allocation Unit. These costs cover administrative expenses that support multiple programs and can not be identified as program or grant specific costs.

Costs associated with fixed costs such as lease space, utilities, phone, etc are **not** considered part of the indirect cost pool and are charged directly to the grants where the staff are housed and paid directly from a grant. These fixed costs are standard costs associated with a full time equivalent (FTE) and are developed by the Executive Office of the Governor as part of the Legislative Budget Standards each year. These costs are listed under the "Other" category of the grant.

TOTAL DIRECT AND INDIRECT COSTS **$3,405,228**

BUDGET JUSTIFICATION

SECTION A – PERSONNEL

NOTE: DOH was not given authority to increase the number of full time employees (FTE). Additional staffing needs are being obtained through contracted staff. One OPS position was hired on a temporary basis to begin the development and implementation process of the updated state plan until contracted staff could be hired.

SECTION B - FRINGE
Mandatory benefits for this position are calculated at 1.45% of salary.

SECTION C - TRAVEL
1. Program staff will be required by DOH policy to travel to perform on-site contract monitoring and evaluation.
2. One Department of Health and one Department of Children and Families staff and/or leadership will travel to the grant required federally initiated grantee meeting.

SECTION D – EQUIPMENT
1. No equipment requested.

SECTION E - SUPPLIES
2. General office supplies and computer supplies used by staff to carry out daily activities of the program.

SECTION F – CONTRACTUAL
1. Contract with an entity to plan, research, develop, review, coordinate, compile and submit to the DOH the MIEC Home Visiting Needs Assessment report as outlined and required by the Affordable Care Act (ACA) MIEC Home Visiting Program, CFDA 93.505.
2. Contract with an entity to plan, research, develop, review, coordinate, compile and assist with the updated state plan final grant submission.
3. Contract with an entity to evaluate the implemented models.
4. Contract with five entities identified by the MIEC Home Visiting Program in local communities throughout the state.
5. Contract with entities to review and evaluate the RFA's
6. DOH was not given authorization to increase the number of full time employees (FTE). Additional staffing needs were obtained through contracted staff. Contracted personnel fringe benefits. The benefits package is administered through a staff contracting entity at a set amount outlined below:
   Mandatory Benefits calculated at 15% of salary
   Benefits package calculated at the family rate of $14,448
   Administrative Fee calculated at 7% of salary +mandatory benefits + benefits package

Program Administrator (DOH and DCF)
Amount based on state pay standards for this class specification. One of these two contracted staff will be located at DOH Central Office, Bureau of Family and Community Health and the other at DCF Central Office, Family Safety Program Office. Responsibilities include supervision of the programmatic development, project and contract management and overall daily management of the MIEC Home Visiting program. The DOH program administrator will have on-site management of program staff to ensure that the program is implemented as outlined by the grant guidance and in accordance with the updated state plan.

Community Health Nursing Consultant: Program Staff (DOH)
Amount based on state pay standards for this class specification. This contracted position will be located at DOH Central Office within the Bureau of Family and Community Health. Responsibilities include assisting the Program Administrator with the development and implementation of the MIEC Home Visiting

Florida's MIECHV Program Implementation Timeline for FFY 11-12

	Month													
Activity	6/11	7/11	8/11	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12
Write Request For Information for Promising Practices applications														
Five initial contracts in process with agencies														
Write Purchase Order for University independent evaluators														
Post Request For Information for Promising Practices														
Engage Independent Evaluators														
Select Task Force Members														
Engage Coalition members														
Begin Request For Application revision														
Hold first Task Force meeting														
Select core competency topics														
Complete Request For Application														
Attend model trainings														
Process quarterly invoices and reports														
Start University contract amendment														
First clients served in initial five areas														
Post Request For Application														
Select individual evaluators for RFA review														
Process purchase orders for evaluators														

	Month													
Activity	6/11	7/11	8/11	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12
Amendment for university contract complete														
Provide technical assistance on data training														
Score reviewed applications														
Hold second Task Force meeting														
Select new areas for implementation														
Process quarterly invoices and reports on first five areas														
Technical assistance as needed														
Hold HV Coalition meeting														
New contracts completed														
Rework initial five contracts as needed														
Technical assistance visits														
Process quarterly invoices and reports														
Hold statewide meeting for all programs														
Hold second HV Coalition meeting														
First clients served in new areas														
Hold third Task Force meeting														

***This timeline does not include the activities of the evaluation team's timeline.**

APPENDIX 9

FLORIDA EARLY CHILDHOOD COMPREHENSIVE SYSTEMS (ECCS) GRANT

Overview of Interagency Agreements between Florida Departments and Agencies Providing Services to Children and Youth

Title	Participating Departments/Agencies	Description	Additional Information
Infants and Toddlers Early Intervention Program	Florida Department of Health, Children's Medical Services, Early Steps Florida Department of Education, Bureau of Instructional Support and Community Services Florida Department of Education, Division of Blind Services Florida Department of Children and Families Head Start, Early Head Start and related programs Florida School for the Deaf and Blind	Define and clarify the responsibilities of each agency in order to ensure the statewide provision of coordinated quality early intervention services, including transition and family centered services in natural environments for children with disabilities from birth to three years of age and their families.	Addresses development of joint initiatives; non-duplication of early intervention services; awareness of full range of services available; sharing of training, technical assistance and assistive technology resources; development of interagency agreements among local agencies; and outlines specific individual agency and joint responsibilities. Established to meet requirements of the Individuals with Disabilities Education Act, Part C, Early Intervention Services.
Support for Children in Child Welfare	Department of Education Department of Children & Families Agency for Workforce Innovation	Review and ensure coordination of rules, regulations, policies and procedures relative to the education, special education and related services, job training and employment of children in the child welfare system; define and establish communication protocols; promote joint updating of policies and staff training; provide access to pertinent staff and parent training opportunities; coordinate efforts addressing educational stabilization, transportation, data and information-sharing to the extent possible and case planning.	Requires agency designees to meet annually, at a minimum, and make recommendations to the Secretary of the Department of Children and Families, the Commissioner of Education and the Director of the Agency for Workforce Innovation; addresses appointment of district school board, regional workforce board and Department of Children and Families district/ regional liaisons.

Title	Participating Departments/Agencies	Description	Additional Information
Assistive Technology	Department of Health, Infant and Toddler Intervention Program Department of Education, Division of Blind Services Department of Education, Division of Vocational Rehabilitation	Provide a mechanism by which a youth with disabilities, or his or her parent, are informed of assistive technology devices to support transitions and may request that an assistive technology device remain with the youth as she or he moves through the continuum from home to school, to another	Established based on 1003.575, Florida Statutes.
	Department of Education, Office of Early Learning Agency for Workforce Innovation, Office of Early Learning Department of Education, Bureau of Exceptional Education and Student Services	school district, to postsecondary institutions, to state or community agencies, to employment facilities and to community living facilities.	
Infants and Toddlers with Sensory Loss	Department of Health, Children's Medical Services, Early Steps Florida School for the Deaf and Blind, Outreach Services, Parent Infant Program	Facilitate delivery of appropriate and quality early intervention services to children, ages birth to 36 months, with sensory loss (vision and/or hearing) and their families by clarifying roles and responsibilities of each agency.	
Child Care Licensing	Department of Children and Families Department of Health	Provide for coordination of licensing inspections twice a year at licensed child care centers in 61 Florida counties.	Established to meet requirements of Section 402.305, Florida Statutes. The remaining six counties have elected to conduct their own licensing inspections, meeting or exceeding state licensing requirements.

Title	Participating Departments/Agencies	Description	Additional Information
Improving Child Care Quality	Agency for Workforce Innovation Department of Education	Improve the quality of child care programs through additional statewide assistance and supports.	
Data-sharing for Child Support Enforcement	Agency for Workforce Innovation Department of Revenue, Child Support Enforcement	Provide disclosure of confidential Unemployment Compensation information on persons who owe a duty of child support and to deduct and withhold child support payments from such person's Unemployment Compensation benefits.	
One-stop Service Centers	Department of Education Agency of Workforce Innovation	Strengthen the one-stop system, including the role of the Division of Vocational Rehabilitation – assist families in finding employment.	Established based on Chapter 413, Florida Statutes.
Services to Homeless Children and Families	Department of Education Department of Children and Families	Provide services to homeless children and to the families of such children and youth, as needed.	Established based on 1003.21(1)(f), Florida Statutes.
Abuse Hotline	Department of Education Department of Children and Families	Provides for DOE to contact the Abuse Hotline of complaints involving reports of abuse, neglect, or abandonment at nonpublic schools.	
Pre-kindergarten Services for Children with Disabilities	Department of Education Head Start Programs	Development of programs designed to provide special education and related services to pre-kindergarten children with disabilities and their families.	

Title	Participating Departments/Agencies	Description	Additional Information
Data-sharing – Kindergarten Screening	Department of Education Agency Workforce Innovation	Coordinate kindergarten screening results of children participating in school readiness programs by "matching" Agency for Workforce Innovation school readiness data with the Department of Education's data on kindergarten screening results.	Cooperative initiative, not a formal interagency agreement
Waivers for Developmental Disabilities	Agency for Persons with Disabilities Agency for Health Care Administration	Delineation of agencies' responsibilities for administration and operations for Medicaid Consumer Directed Care Research and Demonstration 1115 Waiver, Developmental Disabilities Waiver, Family/Supported Living Waiver, and Intermediate Care Facility Services for the Developmentally Disabled Program.	Established in 2005.
Disability Coordination	Agency for Persons with Disabilities Department of Health	Outlines the creation, administration and funding of a Statewide Disability Coordinator.	Established in 2007.
Champions for Children	Department of Children and Families Department of Juvenile Justice Agency for Persons with Disabilities Agency for Health Care Administration Department of Health	Creates local system of care review teams to serve area coordinated multi-agency integrated review teams on behalf of children and families served by several agencies. Requires the assignment of a "Champion" to ensure that the child and families needs are met in a timely manner. Establishes a Headquarters Rapid Response Team in Tallahassee to provide assistance to the local teams. Creates a Headquarters Multi-Agency Meeting on a regular basis to collaborate on developing interagency strategies and initiatives to improve service coordination.	Established in 2008.

Formally Established Interagency Groups

In addition to the Interagency agreements displayed above, the state also has formally established interagency groups in operation. The chart below describes those groups.

Interagency Group	Membership	Purpose
Florida Coordinating Council for Infants and Toddlers (FICCIT)	Parents Service providers (public or private) State legislator Personnel Preparation Agency for Early Intervention Services Agency for Preschool Services Agency for Health Insurance Head Start Agency A Child Care Agency	The role of FICCIT is to assist public and private agencies in implementing a statewide system of coordinated, comprehensive, multidisciplinary, interagency programs providing appropriate early intervention services to infants and toddlers with disabilities and risk conditions and their families.
Florida KidCare Coordinating Council	Florida Hospital Association Agency for Health Care Administration Department of Children and Families University of Florida Family Café, Inc. Florida Healthy Kids Children's Board of Hillsborough Florida Legal Services HMOs	The Council is responsible for making recommendations to the Governor concerning the implementation and operation of the Florida KidCare state children's health insurance program.

Interagency Group	Membership	Purpose
	Office of Insurance Regulation Agency for Persons with Disabilities Florida Dental Association Child Advocate Department of Education Lawton and Rhea Chiles Center Farm worker Self-help Council on Indian Affairs Blue Cross and Blue Shield Florida Pediatric Society Institute of Family Involvement Florida League of Cities Florida Association of Counties Department of Health	
Early Learning Advisory Council	Board Chairs of the 31 Early Learning Coalitions as well as a representative of the House and Senate.	The Early Learning Council (ELAC) was established by Florida Statute, s. 1002.77. The purpose of the advisory council is to submit recommendations on the early learning policy of the state to the Governor's office through the Agency for Workforce Innovation, including the administration of the Voluntary Pre-kindergarten, School Readiness, and Child Care Resource and Referral programs. The agenda of the council is to run the coalitions like a business, to maximize the money from the state, and to ensure that our youngest children are prepared to enter school. The advisory council meets quarterly at different locations across the state.

Interagency Group	Membership	Purpose
Florida Association of Healthy Start Coalitions	Consumers of family planning, primary care, or prenatal care services, at least two of whom are low-income or Medicaid eligible, County Health Departments, Migrant and Community Health Centers, Hospitals, Local medical societies, Local health planning organizations, Local Health Advocacy Interest Groups, County and Municipal Governments, Social Service Organizations, and Local Education Communities	The Healthy Start Coalitions were established in 2001 by Florida Statute, s.383.216. The purpose of the coalitions is to establish a partnership among the private sector, the public sector, state government, local government, community alliances, and maternal and child health care providers, for the provision of coordinated community-based prenatal and infant health care.

APPENDIX 10

FLORIDA'S MEMORANDA WITH STATE AGENCIES

Maternal, Infant and Early Childhood Home Visiting Program Memorandum of Agreement (MOA)

Between

Florida Department of Health in Collaboration With Florida Department of Children and Families
and
Agency for Health Care Administration

The Department of Health (DOH) in collaboration with the Department of Children and Families (DCF), and the Agency for Health Care Administration (AHCA), enter into this agreement with the intent of ensuring a cooperative, coordinated, and collaborative approach to achieve the purposes stated in the Social Security Act, Title V, Section 511 (42 U.S.C. 701), as amended by the Patient Protection and Affordable Care Act (PPACA) of 2010 (P.L. 111-148), Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.

I. Purpose & Scope

The purpose of Section 511 is to establish Home Visiting programs across the state to: (1) to strengthen and improve the programs and activities carried out under this title; (2) to improve coordination of services for at-risk communities; and (3) to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

The DOH, in collaboration with DCF, has received federal grant funding to implement, Florida's MIECHV program. The intent is for Federal, State, and local agencies, through their collaborative efforts, to develop one service strategy aimed at developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development, and strong parent-child relationships in targeted at-risk community(ies). The MIECHV program is expected to promote the following outcomes: improved maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports. To support these initiatives and to fulfill two critical grant requirements, upon which federal grant funding is contingent, the participating agencies will collaborate and perform duties as described in this Memorandum of Agreement (MOA).

This MOA recognizes that the participating agencies share the common goal of promoting the well-being of their respective clients. Additionally, these agencies serve mutual clients and, in doing so, come in contact with clients at vital stages in their respective lives. Furthermore, these mutual clients experience multi-faceted and multi-

dimensional circumstances, which create a critical need for a multi-agency approach to facilitate the establishment of an integrated system of care to ensure holistic provision of services.

II. DOH/DCF/AHCA Joint Responsibilities under this MOA

DOH in collaboration with DCF and AHCA shall perform the following activities:

1. The MIECHV grant requires the collaboration of state agencies involved in matters affecting early childhood to ensure the MIECHV program is part of a continuum of early childhood services in Florida. To fulfill this requirement, each participating agency shall designate a representative to serve on Florida's Home Visiting Task Force to assist in the planning, development, coordination, implementation, and continued successful execution of the MIECHV program.

2. The MIECHV grant requires continuous data collection and evaluation of the MIECHV program. To fulfill this requirement, AHCA agrees to provide the required data elements that exist in data sets and computer systems owned by AHCA. These will be provided by AHCA through the established Data Use Agreement process.

III. Review

This agreement will be reviewed annually by all parties to ensure adequate identification of support requirements. Additional reviews may take place when changing conditions or circumstances require substantial changes or development of a new agreement. Changes may be made at any time by attaching an amendment to the basic document. Any amendment to this MOA shall be in writing and signed by both parties.

IV. Miscellaneous Provisions

Exchange of Confidential Information – Section 381.0022, F.S., governs the disclosure or exchange of information between parties.

Termination – Either party may terminate this agreement without cause, upon thirty days written notice to the other parties.

V. Effective Date and Signature

This agreement becomes effective upon the date of the last approving signature and will remain in effect for one year unless otherwise amended or terminated.

The undersigned officials are duly authorized to execute on behalf of their agencies and by their signature indicate their agencies agreement with this MOA.

Signatures and dates:

FOR:
Florida Department of Health

H. Frank Farmer Jr.
Print Name

H. Frank Farmer Jr.
Signature

Surgeon General
Title

28 APR 2011
Date

FOR:
Florida Department of Children and Families

David Wilkins
Print Name

David Wilkins
Signature

Secretary
Title

06/01/11
Date

FOR:
Agency for Health Care Administration

Print Name

Signature

Title

Date

3

Maternal, Infant and Early Childhood Home Visiting Program Memorandum of Agreement (MOA)

Between

Florida Department of Health in Collaboration With Florida Department of Children and Families
and
Agency for Workforce Innovation

The Department of Health (DOH) in collaboration with the Department of Children and Families (DCF), and the Agency for Workforce Innovation (AWI), enter into this agreement with the intent of ensuring a cooperative, coordinated, and collaborative approach to achieve the purposes stated in the Social Security Act, Title V, Section 511 (42 U.S.C. 701), as amended by the Patient Protection and Affordable Care Act (PPACA) of 2010 (P.L. 111-148), Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.

I. Purpose & Scope

The purpose of Section 511 is to establish Home Visiting programs across the state to: (1) to strengthen and improve the programs and activities carried out under this title; (2) to improve coordination of services for at-risk communities; and (3) to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

The DOH, in collaboration with DCF, has received federal grant funding to implement, Florida's MIECHV program. The intent is for Federal, State, and local agencies, through their collaborative efforts, to develop one service strategy aimed at developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development, and strong parent-child relationships in targeted at-risk community(ies). The MIECHV program is expected to promote the following outcomes: improved maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports. To support these initiatives and to fulfill two critical grant requirements, upon which federal grant funding is contingent, the participating agencies will collaborate and perform duties as described in this Memorandum of Agreement (MOA).

This MOA recognizes that the participating agencies share the common goal of promoting the well-being of their respective clients. Additionally, these agencies serve mutual clients and, in doing so, come in contact with clients at vital stages in their respective lives. Furthermore, these mutual clients experience multi-faceted and multi-

dimensional circumstances, which create a critical need for a multi-agency approach to facilitate the establishment of an integrated system of care to ensure holistic provision of services.

II. DOH/DCF/AWI Joint Responsibilities under this MOA

DOH in collaboration with DCF and AWI shall perform the following activities:

1. The MIECHV grant requires the collaboration of state agencies involved in matters affecting early childhood to ensure the MIECHV program is part of a continuum of early childhood services in Florida. To fulfill this requirement, each participating agency shall designate a representative to serve on Florida's Home Visiting Task Force to assist in the planning, development, coordination, implementation, and continued successful execution of the MIECHV program.

2. The MIECHV grant requires continuous data collection and evaluation of the MIECHV program. To fulfill this requirement, AWI agrees to provide the required data elements that exist in data sets and computer systems owned by AWI. These will be provided by AWI through the established Data Use Agreement process.

III. Review

This agreement will be reviewed annually by all parties to ensure adequate identification of support requirements. Additional reviews may take place when changing conditions or circumstances require substantial changes or development of a new agreement. Changes may be made at any time by attaching an amendment to the basic document. Any amendment to this MOA shall be in writing and signed by both parties.

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Print Name

David Wilkins
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Secretary
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06/01/11
Date

FOR:
Agency for Workforce Innovation

Print Name

Signature

Title

Date

Maternal, Infant and Early Childhood Home Visiting Program Memorandum of Agreement (MOA)

Between

Florida Department of Health in Collaboration With Florida Department of Children and Families
and
Florida Department of Education

The Department of Health (DOH) in collaboration with the Department of Children and Families (DCF), and the Florida Department of Education (DOE), enter into this agreement with the intent of ensuring a cooperative, coordinated, and collaborative approach to achieve the purposes stated in the Social Security Act, Title V, Section 511 (42 U.S.C. 701), as amended by the Patient Protection and Affordable Care Act (PPACA) of 2010 (P.L. 111-148), Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.

I. Purpose & Scope

The purpose of Section 511 is to establish Home Visiting programs across the state to: (1) to strengthen and improve the programs and activities carried out under this title; (2) to improve coordination of services for at-risk communities; and (3) to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

The DOH, in collaboration with DCF, has received federal grant funding to implement, Florida's MIECHV program. The intent is for Federal, State, and local agencies, through their collaborative efforts, to develop one service strategy aimed at developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development, and strong parent-child relationships in targeted at-risk community(ies). The MIECHV program is expected to promote the following outcomes: improved maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports. To support these initiatives and to fulfill two critical grant requirements, upon which federal grant funding is contingent, the participating agencies will collaborate and perform duties as described in this Memorandum of Agreement (MOA).

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dimensional circumstances, which create a critical need for a multi-agency approach to facilitate the establishment of an integrated system of care to ensure holistic provision of services.

II. DOH/DCF/DOE Joint Responsibilities under this MOA

DOH in collaboration with DCF and DOE shall perform the following activities:

1. The MIECHV grant requires the collaboration of state agencies involved in matters affecting early childhood to ensure the MIECHV program is part of a continuum of early childhood services in Florida. To fulfill this requirement, each participating agency shall designate a representative to serve on Florida's Home Visiting Task Force to assist in the planning, development, coordination, implementation, and continued successful execution of the MIECHV program.

2. The MIECHV grant requires continuous data collection and evaluation of the MIECHV program. To fulfill this requirement, DOE agrees to provide the required data elements that exist in data sets and computer systems owned by DOE. These will be provided by DOE through the established Data Use Agreement process.

III. Review

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David Wilkins
Print Name

David Wilkins
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Secretary
Title

06/01/11
Date

FOR:
Florida Department of Education

Print Name

Signature

Title

Date

3

Maternal, Infant, and Early Childhood Home Visiting Program Memorandum of Agreement (MOA)

Between

Florida Department of Health in Collaboration With
Florida Department of Children and Families
and
Florida Department of Law Enforcement

The Department of Health (DOH) in collaboration with the Department of Children and Families (DCF), and the Florida Department of Law Enforcement (FDLE), enter into this agreement with the intent of ensuring a cooperative, coordinated, and collaborative approach to achieve the purposes stated in the Social Security Act, Title V, Section 511 (42 U.S.C. 701), as amended by the Patient Protection and Affordable Care Act (PPACA) of 2010 (P.L. 111-148), Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.

I. Purpose & Scope

The purpose of Section 511 is to establish Home Visiting programs across the state to: (1) to strengthen and improve the programs and activities carried out under this title; (2) to improve coordination of services for at-risk communities; and (3) to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

The DOH, in collaboration with DCF, has received federal grant funding to implement, Florida's MIECHV program. The intent is for Federal, State, and local agencies, through their collaborative efforts, to develop one service strategy aimed at developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development, and strong parent-child relationships in targeted at-risk community(ies). The MIECHV program is expected to promote the following outcomes: improved maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports. To support these initiatives and to fulfill two critical grant requirements, upon which federal grant funding is contingent, the participating agencies will collaborate and perform duties as described in this Memorandum of Agreement (MOA).

This MOA recognizes that the participating agencies share the common goal of promoting the well-being of their respective clients. Additionally, these agencies serve mutual clients and, in doing so, come in contact with clients at vital stages in their respective lives. Furthermore, these mutual clients experience multi-faceted and multi-

dimensional circumstances, which create a critical need for a multi-agency approach to facilitate the establishment of an integrated system of care to ensure holistic provision of services.

II. DOH/DCF/FDLE Joint Responsibilities under this MOA

DOH in collaboration with DCF and FDLE shall perform the following activities:

1. The MIECHV grant requires the collaboration of state agencies involved in matters affecting early childhood to ensure the MIECHV program is part of a continuum of early childhood services in Florida. To fulfill this requirement, each participating agency shall designate a representative to serve on Florida's Home Visiting Task Force to assist in the planning, development, coordination, implementation, and continued successful execution of the MIECHV program.

2. The MIECHV grant requires continuous data collection and evaluation of the MIECHV program. To fulfill this requirement, FDLE agrees to provide the required data elements that exist in data sets and computer systems owned by FDLE. These will be provided by FDLE through the established Data Use Agreement process.

III. Review

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Print Name

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David Wilkins
Print Name

David Wilkins
Signature

Secretary
Title

06/01/11
Date

FOR:
Florida Department of Law Enforcement

Print Name

Signature

Title

Date

3

State of Florida
Department of Children and Families

Rick Scott
Governor

David E. Wilkins
Secretary

June 7, 2011

Ms. Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
16B-26
Rockville, MD 20857

Dear Dr. Yowell:

The Department of Children and Families fully and enthusiastically supports Florida's Home Visiting Program State Plan. As the state agency responsible for Title II of Child Abuse Prevention and Treatment Act (CAPTA), child welfare services under Titles IV-B and IV-E and as the single State Agency for Substance Abuse Services, the Department of Children and Families knows firsthand the positive impact that successful home visiting models have in preventing child abuse and neglect. The Department and our community based care providers responsible for child maltreatment prevention efforts recognize the value of evidence-based resources like a statewide home visiting system. We concur and support home visiting as a key strategy in supporting families and preventing entry of children into the child welfare system.

The Department of Children and Families and the Department of Health have a longstanding and strong partnership in helping the families of our state and for preserving and strengthening families to prevent child abuse and neglect. The two agencies have collaborated with multiple stakeholders to develop an evidence-based home visiting plan for Florida.

We pledge our support, commitment, and resources to ensure the state's plan is implemented, maintained as effective, and modified when necessary to stay the course for an evidence-based home visiting system statewide.

Sincerely,

David E. Wilkins
Secretary

cc: Marilyn Stephenson, Health Resources and Services Administration, Region 4
Ruth Walker, Administration for Children and Families, Region 4

Rick Scott
Governor
Cynthia R. Lorenzo
Director

April 4, 2011

Audrey Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Dr. Yowell:

As Florida's Child Care and Development Fund Administrator, I write this letter to document my support for the work being accomplished to implement the Maternal, Infant, and Early Childhood Home Visiting Program. As the Director of the Office of Early Learning within the Agency for Workforce Innovation, I partner and work directly with leadership at both the Department of Health (DOH) and the Department of Children and Families (DCF) to achieve shared goals of ensuring the high quality of services to our youngest children and their families.

The Agency's Office of Early Learning is currently working on infrastructure projects related to services for children ages birth to eight including streamlining child screening and assessment, and program evaluation. Further, we are working to build a professional development system for our teachers of children younger than age five including a career pathway, core competencies for what teachers should know and be able to do with children in the classroom, outcomes driven training for those who train our teachers, and a registry which is a data warehouse to track the professional development progress of teachers and trainers. In these efforts we are partnering with other state agencies, programs, and stakeholders vested in quality outcomes for children.

As parents are children's first and most important teachers, the Agency's Office of Early Learning supports the work of the Division of Family Health Services and the Home Visiting Program. We look forward to partnering to ensure that Florida's efforts are built with the goal of collaboration and coordination.

Sincerely,

Brittany Oliveri Birken, Ph.D.
Director
Office of Early Learning
Agency for Workforce Innovation

Agency for Workforce Innovation
The Caldwell Building, Suite 100•107 East Madison Street•Tallahassee, Florida•32399-4120
Telephone (850) 245-7105•Fax (850) 921-3223•TTY/TDD 1-800-955-8771-Voice1-800-955-8770
www.floridajobs.org

Rick Scott
Governor
Cynthia R. Lorenzo
Director

April 4, 2011

Audrey Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Dr. Yowell:

As Florida's Director of the State Advisory Council on Early Education and Care, I write this letter in support of the work currently underway for the Maternal, Infant, and Early Childhood Home Visiting Program.

As the Director of the newly formed Advisory Council, one of my primary goals is to reach out and build partnerships among and within agencies. I have met with the Florida Home Visiting team twice and we have committed to work together to ensure that the goals of the Home Visiting plan are aligned, compliment and support those efforts set forth by the Advisory Council.

I look forward to partnership and believe a great deal of change in the lives of families and young children will result.

Sincerely,

Stacy Howard, Ph.D.
Director
State Advisory Council
Office of Early Learning
Agency for Workforce Innovation

Agency for Workforce Innovation
The Caldwell Building, Suite 100•107 East Madison Street•Tallahassee, Florida•32399-4120
Telephone (850) 245-7105•Fax (850) 921-3223•TTY/TDD 1-800-955-8771-Voice1-800-955-8770
www.floridajobs.org

Florida's Head Start State Collaboration Office

April 14, 2011

Ms. Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Ms. Yowell:

Florida's Head Start State Collaboration Office is pleased to write this letter in support of the Florida Department of Health's proposal to the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau Funding Opportunity Announcement *"Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Funding Opportunity Number HRSA-10-275."*

Florida's Head Start Collaboration Office represents the interests of Head Start, Early Head Start and Migrant and Seasonal Head Start programs in the state and supports collaborative partnerships at the state and local level. As indicated by national studies, Early Head Start is an evidenced-based and comprehensive early childhood program for infants and toddlers, which uses home visiting as one of its service delivery models. In Florida, thirteen percent of Early Start grantees use home visiting as their primary service delivery model. Early Head Start grantees are poised to support the coordination of services to at-risk families through this initiative. As part of this plan, the Head Start State Collaboration Office will work with the Florida Department of Health, the Florida Department of Children and Families and other organizations to implement our plan by identifying ways in which Early Head Start can contribute to the deliverance of high quality early childhood visitation, avoid duplication of services, and utilize resources to the greatest extent possible.

In conclusion, we support the efforts of the Florida Department of Health as they seek funding to support the Maternal, Infant and Early Childhood Home Visiting Program and look forward to working collaboratively on this important public health activity.

Sincerely,

Lilli J. Copp

Lilli J. Copp, Director
Head Start State Collaboration Office

FLORIDA DEPARTMENT OF HEALTH

Rick Scott
Governor

March 10, 2011

Audrey Yowell, PhD, MSSS
Heath Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
18A-39
Rockville, MD 20857

Dear Dr. Yowell:

As the Title V Director for Florida, it is my pleasure to share our progress and commitment to implement the Maternal, Infant, and Early Childhood Home Visiting Program. The Department of Health (DOH) and the Department of Children and Families (DCF) have worked diligently and in cooperation these past few months to prepare our Updated State Plan detailing how Florida will realize the intent of the legislation. DOH and DCF are committed to ensuring that our most vulnerable communities receive these funds to initiate or expand evidence-based home visiting programs. We are confident these programs will provide families with the information and resources needed to improve maternal and child outcomes.

Other state agencies responsible for the provision of services to at-risk families are working with us to design an infrastructure at the state and local level and to ensure processes are in place to continue to build upon the collaborative efforts already in existence. As partners, these agencies will strive to establish an integrated system of care to meet the complex and diverse needs of at-risk families and communities in Florida.

The Division of Family Health Services within the Florida Department of Health oversees numerous programs designed to meet the needs of women, infants and children. We look forward to contributing to the delivery of high quality home visiting programs; avoid duplication of services, and maximize utilization of resources.

Sincerely,

Annette Phelps

Annette Phelps, A.R.N.P., M.S.N.
Director, Division of Family Health Services

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